Trauma Data Collection File Specification

For XML Data Filers

May 2018

Version 3.22

2016 Submissions

This edition is effective for all
trauma patients presenting for
treatment on or after October 1, 2015

Bureau of Health Care Safety and Quality
Massachusetts Department of Public Health

Acknowledgements

The Bureau of Health Care Safety and Quality would like to thank the myriad of people – too numerous to list here – who have worked tirelessly to create the Massachusetts Trauma Registry. The current upgrades to the system and variable list are being done to continue the growth of the trauma registry and keep building on their knowledge and hard work.

Massachusetts Trauma Registry is maintained by the Bureau of Health care Safety and Quality, 99 Chauncy Street, 11th Floor, Boston, MA 02111. For more information about the Massachusetts Trauma Registry, contact the Massachusetts Department of Public Health, Bureau of Health Care Safety and Quality (Bureau), at (617)-753-8000, or visit http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/oems/trauma-data/public-health-oems-trauma-system.html

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Revision History

03/06/2008 Altered the Record Specification Elements to allow for Multiple Entry for Glasgow Coma Score Assessment Qualifier in the ED Drug Use Indicators and AirBag Deployment.

03/06/2008 Altered the lookup values for GCS Assessment Qualifiers (table 8) they appeared to be out dated.

04/09/2008 Changed severity of FilingOrgID and SiteOrgID from A Error to Drop File

04/22/2008 Revised "Data to Include…" section, Incident City (remove reference to incident zip) and Drug Use Indicator (make all occurrences conditional), added Incident State and Transport Mode.

06/03/2008 Revised the Incident City to be the text description of the city instead of the FIPS Code.

06/23/2008 Revised the Patient City to be the text description of the city instead of the FIPS Code. Revised Incident State to be the 2 digit postal code instead of the FIPS Code. Removed the requirement of Non Trauma Centers to supply Drug Use Indicators.

06/30/2008 Revised to synchronize required flags

07/02/2008 Revised to make remove reference to remove reference to patient's industry and patient's occupation

07/02/2008 Revised to change the field name Inpatient or Observation Date and Time to ED/Hospital Arrival Date and Time

07/11/2008 Revised date of document, submittal schedule, added an option "9-Unknown" for Transport Mode added "9 Not possible to assign" to AIS

7/15/2008 Revised to remove the language "For Trauma Centers" from the RecordType20 since at least 1 recordtype20 is required for both Trauma and non-Trauma centers

08/06/2008 Revised Drug Use Indicator and CoMorbidity lookup table values. Added maximum record counts to Co Morbid and Complication records.

11/23/2009 Correction to differences Between Trauma File Specification Version 1.0 and Version 2.0, Primary Ecode is required in current and all previous specification versions.

12/31/2015 Update the Specification Guide to reflect the changes in data elements, additional sections to clarify the submission process, more specific information on the data that is being collected, and supplementing any additional information.

2/10/2016 Page 6 - Field Values added for Not Known and Not Applicable to make consistent with NTDB. Removed reference to custom Not Known and Not Applicable reference in columns 73 and 74.

3/29/2016 .XSD Added, Table of Contents Updated, removed domain definitions from lower .XSD, added XML sample file

3/30/2016 Removed 2 grids from the section Record Specification Elements and altered the language so that it matches the original XML guide.

3/31/2016 Formatting and adding in Error Types to the table.

4/5/2016 Formatting and changing some sections wording.

4/7/2016 Change coding range and added to exclusions for ICD10 Primary External Cause Code. Added X in non-Trauma Center column for Transport Mode.

4/11/2016 Removing column 23 Primary External Cause Code. Altered definition of column 52 to make consistent with column 75 of fixed length guide. Renamed field 104 to Additional ICD 10 External Cause Code and removed reference to Record Type 70. Altered the grid and XSD to show multiple entry. Removed from the .XSD the element Primary External Cause Code.Added an X for must be filled by non-trauma centers for field ICD10 Primary External Cause Code. Added an X for must be filled by non-trauma centers for field ICD10 Place of Occurrence External Cause Code. Removed X from Additional ICD10 Primary External Cause Code for non-Trauma centers. Removed X from Transport Mode for non-Trauma centers. Added an X for must be filled by non-trauma centers for field Hospital Discharge Date. Removed X from Service Level for non-Trauma centers.Removed X from Other Transport Mode 1-5 for non-Trauma centers.

4/12/2016 Made lowercase x's capital X's in field ED Discharge Date and ED Discharge Time. Added X to field Transport Mode for non-trauma centers. Added the Max Occurs of 50 in the XSD for Injury Diagnosis and to the grid.Added Unlimited to Protective Devices in the grid. Added the Max Occurs of 10 to the Hospital Complications element in the XSD. Added the Max Occurs of 200 to the Hospital Procedure Code element in the XSD and in the grid. Added language for a restriction of Additional ICD10 Primary External Cause Code records per Trauma record in the grid and a Max Occurs in the .XSD.

5/17/2016 Added back Primary Ecode ICD-9-CM, Location Ecode ICD-9-CM, and ICD-9-CM Diagnosis Code

7/7/2016 Made consistent XML element names in Grid, .XSD, and sample file so they match what the Trauma application requires.

7/12/2016 Added in the ICD-10 External Cause Coding criteria in Trauma Data Overview Section and clarified the Primary External Cause Code and Additional External Cause Code exclusion criteria in Record Type tables.

7/22/2016 Added notes about the XML Element Tags coding and Element Tags naming convention.

8/2/2016 Added in Data Collect Requirement Section more guidelines about the quarter submission due date. Added in Validation Edit Report more explanation about errors and identifiers needed to verify submission file errors.

8/22/2016 Added in unknown and/or not applicable coding to several coded fields and unknown and/or not applicable coding in fields with date and time. Change error types to either a warning or an error type B category specifically to the new data elements to loosen criteria while hospitals adjust to submitting them.

9/23/2016 Updated the Injury Diagnosis data field edit information to specify the inclusion criteria codes to be in the first data field while other coding can be incorporated in the rest of the data fields.

1/3/2017 Remove the choice of entering '99999' for unknown or '88888' for unknown and foreign zip code. This will leave only '999999999' for unknown and '888888888' for unknown and foreign zip code.

6/26/2017 Added to Airbag Deployment 1-3 code 8: 'Not Applicable' and code 9: 'Unknown'. Added to Signs of Life code 99: 'Unknown'. Added in ED/Hospital Blood Pressure code 999: 'Unknown' and code 888: 'Not Recorded', ED/Hospital Pulse Rate code 999: 'Unknown' and code 888: 'Not Recorded' , and ED/Hospital Respiration Rate code 999: 'Unknown' and code 888: 'Not Recorded'. Added a sentence to the data collection requirement section of the specification guide to specify the use of the 'unknown', 'not applicable', and 'not recorded' coding.

7/17/2017 Added to Protective Devices code 88: 'Not Recorded' and code 99: 'Unknown'. Added a sentence to the data collection requirement section of the specification guide to specify the use of the 'unknown' and 'not recorded' coding.

8/23/2017 Added to the Initial ED/Hospital Oxygen Saturation code 888: 'Not Recorded' and code 999: 'Unknown'. Added to the Initial ED/Hospital Respiratory Assistance code 9: 'Unknown'. Include Oxygen Saturation to the Common Null Value section.

8/25/2017 Added to Initial ED/Hospital Temperature code 99.9: 'Unknown' and code 88.8: 'Not Recorded'. Added to Initial ED/Hospital Height code 999: 'Unknown'. Added to Initial ED/Hospital Weight code 999: 'Unknown'.

5/3/2018 Injury Incident Date - when there is a partial date where only the month and year are able to be determine but the day is not able to be confirmed then enter '01'.

5/10/2018 The overall percentage of errors for file submission was raised from 1% to 5% in order to allow 5 failed records (failing for A or B errors) per 100 records to be in a passing submission for the remainder of the 2016 submission files that need to be submitted and processed.

5/30/2018 Add Not Taken to code 9. Unknown for Initial ED/Hospital Respiratory Assistance, code 888 Not Recorded for Initial ED/Hospital Oxygen Saturation, and 88.8 Not Recorded for Initial ED/Hospital Temperature. Change from A or B type errors to warnings for ED/Hospital Admission Time, Injury Incident Time, ED Discharge Time, Hospital Procedure Start Time, and Hospital Discharge Time.

5/31/2018 Change from B type errors to warnings for ICD 10 Hospital Procedure Code and Hospital Procedure Start Date.

Data Collection Requirement

The Trauma Registry is a state database to which all hospitals are required to submit their trauma records, in accordance with the Department's Hospital Licensure regulations (105 CMR 130.851 and 105 CMR 130.852) and Circular Letter (DHCQ 08-03-483, which is currently in the process of being updated). Submission of the state trauma data is based on the criteria that are outlined in the submission guides. Any hospital that does not receive any trauma patients needs to send an e-mail to verify that they have no trauma patients entering into their institution.

The trauma registry data initial submission is required to be submitted on the designated submission quarter due date. If the records for the designated quarter are completed and closed by the hospital prior to the submission date, the hospital may submit the data early to the trauma registry for that designated quarter.

Trauma Registry personnel may, at their discretion, and for good cause, grant an extension in time to a hospital submitting trauma data.

If the Validation Detail Report indicates to a hospital it is required to resubmit data after the initial submission quarter due date because the submission was rejected **or as part of a data verification process**, the hospital must submit its data no later than 30 days following the date of the notice to resubmit. If the data is resubmitted after 60 days, the hospital will need to

notify the trauma registry in order to unlock the flag field, signifying which submission file was most recently received.

The use of ‘unknown’, ‘not applicable’, and ‘not recorded’ should be used as a last resort coding option after all other data resources have been exhausted for the specific variable being recorded.

Submittal Schedule

Trauma Data File **must be submitted quarterly** to Health Safety Network (HSN) and must be submitted within 75 days of the close of the quarter. Include records whose final discharge date must be within the quarter of submission.

Quarter	Quarter Begin & End Dates	Due Date for Data File: 75 days following the end of the reporting period
1	10/1 - 12/31	3/16
2	1/1 - 3/31	6/14
3	4/1 - 6/30	9/13
4	7/1 - 9/30	12/14

Protection of Confidentiality of Data

HSN shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, the Fair Information Practices Act, to the extent that the data collected there under are "personal data" within the meaning of that statute. In addition, HSN shall ensure that any contract entered into with other parties for the purposes of processing and analysis of this data shall contain assurances such other parties shall also comply with the provisions of M.G.L. c. 66A.

Trauma Data Submission Overview

ICD-9 to ICD-10 Transition

The U.S. Department of Health and Human Services (HHS) has mandated that all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) transition from the International Classification of Diseases version 9 (ICD-9-CM) to version 10 (ICD-10-CM/PCS) on October 1, 2014 which was pushed back to October 1, 2015. Massachusetts Trauma Registry will only be collecting ICD-10-CM/PCS starting with patients admitted on or after October 1, 2015.

Massachusetts Trauma Registry Inclusion / Exclusion Criteria ICD-9

A trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria as a principle or primary diagnosis for the state trauma registry:

ICD-9-CM until 9/30/2015

800 - 959.9 or 994.1 or 994.7

AND

Patient Admission Definition:

- Hospital inpatient admission; **OR**
- Observation stay admission; **OR**
- Transfer patient via EMS transport (including air ambulance) from one hospital to another hospital (includes inpatient or observation or emergency department); **OR**
- Death (independent of hospital admission source or hospital transfer status)

Note: When coding out all the variable fields use the best code to describe the direct injury or the information surrounding how the injury occurred. Avoid using non-specified codes unless there is no other code that is better suited for the field after reviewing all the necessary documentation around the injury.

Massachusetts Trauma Registry Inclusion / Exclusion Criteria ICD-10

A trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria as a principle or primary diagnosis for the state trauma registry:

ICD-10-CM starting 10/1/2015

S00 – S99 with 7th character modifiers of A, B, or C only (Injuries to specific body parts – initial encounter)
T07 (unspecified multiple injuries)
T14 (injury of unspecified body region)
T20 – T28 with 7th character modifier of A only (burns by specific body parts – initial encounter)
T30 – T32 (burn by TBSA percentages)
T79.A1 – T79.A19 (Upper extremity) T79.A2 - T79.A29 (Lower extremity) with 7th character modifier of A only (Traumatic Compartment Syndrome (extremity only) – initial encounter)

T75.1 with 7th character modifiers of A only (Unspecified effects of drowning and nonfatal submersion – initial encounter)
T71 with 7th character modifiers of A only (Asphyxiation / Strangulation – initial encounter)

Excluding the following isolated injuries:

S00 (Superficial injuries of the head)

S10 (Superficial injuries of the neck)
S20 (Superficial injuries of the thorax)
S30 (Superficial injuries of the abdomen, pelvis, lower back, and external genitals)
S40 (Superficial injuries of the shoulder and upper arm)
S50 (Superficial injuries of the elbow and forearm)
S60 (Superficial injuries of the wrist, hand, and fingers)
S70 (Superficial injuries of the hip and thigh)
S80 (Superficial injuries of the knee and lower leg)
S90 (Superficial injuries of the ankle, foot, and toes)

Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.

AND

Patient Admission Definition:

- Hospital inpatient admission; **OR**
- Observation stay admission; **OR**
- Transfer patient via EMS transport (including air ambulance) from one hospital to another hospital (includes inpatient or observation or emergency department); **OR**
- Death (independent of hospital admission source or hospital transfer status)

Note: When coding out all the variable fields use the best code to describe the direct injury or the information surrounding how the injury occurred. Avoid using non-specified codes unless there is no other code that is better suited for the field after reviewing all the necessary documentation around the injury.

FOR ICD-10-CM External Cause Code:

MUST be present if principal diagnosis is an injury: ICD-10-CM **(S00-S99)** or the following T-Codes:

(T07) unspecified multiple injuries
(T14) injury of unspecified body region
(T20-T32) burns and corrosions
(T79.A1 – T79.A19) upper extremity
(T79.A2 - T79.A29) lower extremity
(T75.1) drowning or nonfatal submersion
(T71) asphyxiation / strangulation

- If present, **MUST** be a valid ICD-10-CM External Cause Code of **V00-Y38, Y62-Y84** (3 - 7 digits with decimal point excluded).

- **ASSOCIATED** diagnostic fields may be used for additional external cause codes (V, W, X, Y) including supplemental codes: Y90-Y99 (place of injury, activity, status) and Z00-Z99 (factors influencing health status and seeking services).

Common Null Value

Definition

Common Null Value is a term used with Trauma Registry Data Elements to describe a blank field for specifically-defined data fields when an answer cannot be provided.

Field Values

Blank field – Not Applicable/Not Known/Not Recorded/Not Documented

Date and Time Coding

99:99 - Not Applicable/Not Known/Not Recorded/Not Documented

99999999 - Not Applicable/Not Known/Not Recorded/Not Documented

XXXXXX01 – If partial date is the only date available for the Injury Incident Date then make sure month and year are filled in with the known information. The date can be filled in as the first of the month or '01' in spaces that represent the date.

Coded Unknowns

9, 99, 999999999, 888888888, and 999999.9

ED/Hospital Temperature

99.9 = Unknown and 88.8 = Not Recorded

ED/Hospital Height and ED/Hospital Weight

999 = Unknown

ED Discharge Disposition

99 = Not Applicable and 88 = Unknown

Airbag Deployment 1 -3

8 = Not Applicable and 9 = Unknown

ED/Hospital Blood Pressure, ED/Hospital Pulse Rate, ED/Hospital Respiration Rate, and ED/Hospital Oxygen Saturation

888 = Not Recorded and 999 = Unknown

Protective Devices

88 = Not Recorded and 99 = Unknown

Additional Information

- *Not Applicable:* This null value code applies if, at any time of patient care documentation, the information requested was "Not Applicable" to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be *NA* if a patient self-transports to the hospital.

- *Not Known/Not Recorded/Not Documented:* This null value applies if, at the time of patient care documentation, information was "Not Known" (to the patient, family, healthcare provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information, but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as "Unknown". Another example, Not Known/Not Recorded/Not Documented should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for patient transported by EMS).

Validation Edit Report

Once the file is submitted through the INET application software, a validation edit report is generated and sent back through INET to the submitter. It is the responsibility of the submitter to get the report from INET and make sure that the file passed all edit checks. The validation edit report specifies the edit errors that triggered the file failure. The submitting team has 30 days to resubmit the file. The file needs to be reprocessed until there is a passing file sent in for that year and quarter.

When making an inquiry about an error, the Submission Control ID is the identifier for the submission file and the Edit ID is the identifier of the error. These two identifiers are needed to determine what issues are present on the submission file. When emailing the

State Trauma Registry about a submission file that failed or dropped include the Submission Control ID and Edit ID. A warning error is a trigger that will show an error has occurred but it will not count towards failing the submission. See the Trauma Data Quality Standards section for more information about how a submission fails or dropped.

Flag Fields for File Submission

There are two flag fields used to identify the file that should be processed. One flag identifies the most recent file that was sent to be processed (Active) and the other flag identifies the file status (Status). Once a file has been identified as passed and the most recent file, another file sent into the same year and quarter can knock the file out of the most recent file category. The flag field (Active) will be locked into place after 60 days of the last file being entered into the system.

If the submitter is not able to resubmit the file until after 60 days of the original submission, you will need to contact the Bureau epidemiologist to request that the active field is unlocked then resubmit the file.

Resources

Resources for Optimal Care of the Injured Patient – This document corresponds with the evolution of the philosophy of care set by the American College of Surgeons Committee on Trauma (ACS – COT). This is the oldest standing committee of ACS. This document emphasizes the principle that the needs of all injured patient s are addressed wherever they are injured and wherever they receive care. Available at: https://www.facs.org/quality-programs/trauma/vrc/resources/

American College of Surgeons National Trauma Data Standard: Data Dictionary 2016 (NTDB) – This document is designed to establish a national standard for the exchange of trauma registry data, and to serve as the operational definitions for the National Trauma Data Bank. This document will serve as a reference guide when working with the data variables that are being required for the state trauma registry. Available at: http://www.ntdsdictionary.org/ Archives of the data dictionary are available at: http://www.ntdsdictionary.org/softwareVendors/theNTDSArchive.html

ICD - 10 – CM - The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for

classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO). The ICD-10-CM coding contains up to 7 characters and are alphanumeric. Available at: https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html

ICD – 10 – PCS – The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) is used to code out the procedures that were done for the trauma cases. The ICD-10-PCS coding contains 7 characters that represent the section, body system, root operation, body part, approach, device, and qualifier which are coded using the information in the PCS code tables. Available at:https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html

Data File Format

The data for Trauma Data must be submitted in a XML file consistent with the .XSD sample and Massachusetts Trauma XML sample in the back of this guide.

The file layout needs to be set up by the information technology (IT) services in your institution using the samples as guides in the back of this guide. This will help with the transfer of the data from the hospital system to the state trauma registry system.

Data Transmission Media Specifications

Link to Documentation

This is the link to the circular letter, submission guides based on submission type, and the data elements that are required based on trauma designation:
http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/oems/trauma-data/public-health-oems-trauma-system.html

Help Desk Information

If you have any questions or need to set up the SENDS/INET submission system to send in trauma data files, you can contact the HSN help desk. The HSN help desk email is hsnhelpdesk@state.ma.us and the help desk phone number is 1-800-609-7232 for any SENDS/INET questions, updates, and installation.

Applicable Regulations

Terms used in this bulletin are defined in the Hospital Licensure regulations' general definition section (105 CMR 130.020) or are defined in this bulletin. If a term is not otherwise defined, use any applicable definitions from the other sections of the regulation. Relevant sections of the regulation include:

> Designated Trauma Center: A hospital that has been verified by the American College of Surgeons as a level 1, 2 or 3 adult trauma center, or a level 1 or 2 pediatric trauma center, as defined in the document 'Resources for Optimal Care of the Injured Patient: 1999' by the Trauma Subcommittee of the American College of Surgeons (ACS) and its successors; and meets applicable Department standards for designation, or a hospital that has applied for and is in the process of verification as specified in 105 CMR 130.851 and meets applicable. (105 CMR 130.020, definition of "service," (Z))
>
> Data Submission Requirement for Designated Trauma Centers: The hospital provides to the Division of Health Care Finance and Policy (now the Center for Health Information and Analysis – hereinafter, CHIA) the designated trauma center data set to be specified in administrative requirements jointly developed

by the Department and the Division of Health Care Finance and Policy (CHIA), and promulgated by the Department. (105 CMR 130.851(D))

Data Submission Requirement for Hospitals that are not Designated Trauma Centers: (A) The hospital provides to the Division of Health Care Finance and Policy (CHIA) the trauma service hospital data set to be specified in administrative requirements jointly developed by the Department and the Division of Health Care Finance and Policy (CHIA). (105 CMR 130.852(A))

Standard Definitions

Terms used in this document and resources are defined in this section.

Division of Health Care Finance and Policy – Former name of the Center for Health Information and Analysis (CHIA), which monitors a wide variety of health care indicators in Massachusetts to promote improved quality, affordability, access, and outcomes in the Massachusetts health care system. CHIA reports provide data and analysis on providers, insurers, and payers to help legislators, policymakers, insurers, and providers understand the health care indicators in Massachusetts.

Health Safety Net - pays acute care hospitals and community health centers for essential health care services provided to uninsured and underinsured Massachusetts residents. The SENDS/INET applications are provided by HSN to be used by trauma data submitters.

Data Field Service Level Code Definitions

Outpatient Emergency Department Stay: All emergency department visits, including Satellite Emergency Facility visits, by patients whose visits result in neither an outpatient observation stay nor an inpatient admission at the reporting facility.

Outpatient Observation Stay: Patient who receive observation services and who are not admitted. Example: A post-surgical day care patient who, after a normal recovery period, continues to require hospital observation and then is released from the hospital.

Inpatient Stay: Patient who has been admitted as an inpatient visit at the reporting facility.

Death on Arrival: A patient becomes decreased in route to the reporting facility.

Trauma Data Quality Standards

The data will be edited for compliance with the edit specifications set forth in this document. The standards to be employed for rejecting data submissions from hospitals will be based upon the presence of Category A errors as listed for each data element under the following conditions:

All errors will be recorded for each patient Record and for the Submission as a whole. An Edit Report will be provided to the data submitter, displaying detail for all errors found in the Submission.

A Trauma **Record** will be rejected if there is:

- Presence of one or more errors for Category A (A) elements.
- Presence of two or more errors for Category B (B) elements.

A Trauma data **Submission** will be rejected (Dropped) if:

- The file format is not correct
- FilingOrgID on the Record Type 10 does not match the OrgID of the Organization who files the submission on INET
- 1% or more of Trauma records are rejected or
- 50 consecutive records are rejected.

Failed filings must be resubmitted within 30 days.

Warnings – Warnings (W) may be reported on the validation detail reports or edit error reports to Hospitals. These data fields are noted but will not cause a file or record to fail. An example, a date field is not filled out since there is no data available for that case/patient.

Acceptance of data under the edit check procedures identified in this document shall not be deemed acceptance of the factual accuracy of the data contained therein.

Differences Between Trauma File Specification Version 2.0 and Version 3.0 (this version)

More detailed descriptions ICD-10-CM inclusion and exclusion criteria, regulation definitions, data transmission information is updated, clarification to the quality standards, and additional data elements.

Version 3.0 XML File

Version 3.0 will continue to allow for the XML based file and the specified fixed length file format to be accepted into the system. The files will have updated information on how the data is being sent over to the system.

Edits based on Submitting Entity Type

The Trauma Registry will consist of two tier edits performed on the submitted data. The edits performed will be different based on data submitted by trauma centers and that submitted by non-trauma center acute care hospitals that treat trauma centers. The edit differences will be noted in the file specification section below. The Trauma Registry data and its edits will be generally compatible with the ACS's National Trauma Data Bank (NTDB).

Fields no Longer Required

The following fields were required in Trauma File Specification Version 2.0 but are no longer required.

Fields No Longer Required

Discharge Time from Transferring Hospital
ISS Body Region
Locally Calculated ISS
Location of Direct Admission

Trauma Data Record Specification

Record Specification Elements

The Trauma Data File is modeled after the National Trauma Data Bank's National Trauma Data Standard 2016 Data Dictionary. There are several fields that are specific to Massachusetts that will not be a part of the National Trauma Data Standards. All the data variables from the National Trauma Data Standard have not been modified. Every effort has been made to keep the definition of elements found in the National Trauma Data Standard consistent in this specification.

Note: XML submitters need to make sure the element tags that are used in the filing is the same as the field names in the table (upper grid), .XSD, or sample data. For example, "FieldNAME" would need to be "FieldNAME" in the file not FieldName.

F#	Field Name	Must be Filed By Trauma Centers	Must be Filed by Non-Trauma Centers	National Element	XSD Field Name	XSD Data Type	Multiple Entry	Required	Edit Specification	Field Definition	Error Type
1	FilingOrgId	X	X	Yes	FacilityId	xs:string	No	R	Must be present. Characters must be numeric. Must be valid entry as specified in Data Code Tables. (Table I)	The Organization ID assigned by the Center for Center for Health Information and Analysis (CHIA) to the provider filing the submission.	Drop File

2	SiteOrgID	X	X	No	FacilitySiteId	xs:string	No	R	Must be present. Characters must be numeric. Must be valid entry as specified in Data Code Tables. (Table I) Must be equal to the FilingOrgID if the Site and Filing Organization are the same Organization.	The Organization ID assigned by the Center for Health Information and Analysis (CHIA) to the provider of care for the trauma.	Drop File
3	Inter-Facility Transfer	X	X	Yes	InterFacilityTransfer	xs:integer	No	R	Must be Present. Must be a 1 or 2.	Was the patient transferred to your facility from another acute care facility? 1 = Yes 2 = No A patient transferred	A

										from a private doctor's office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport is not considered an inter-facility transfer.	
4	SiteOrgID of Transferring Hospital	X	X	No	FacilitySiteIdOfTransferringHospital	xs:integer	No	C	Must be present if Inter-Facility Transfer is '1' If present and the Transferring Hospital is in-state, must be valid entry as specified in Data Code Tables. (Table 1) If the Transferring Hospital is out	The Organization ID assigned by the Center for Health Information and Analysis (CHIA) to the site from which the patient was transferred.	A

									of state enter '9999999'.		
5	Departure Time from Scene of Transferring	X	X	No	DepartureTimeSceneOrTransferring	Xs:time	No	C	May be present if Inter-Facility Transfer=1. Collected as HH:MM military time. Must range from 00:00 to 23:59 If time is unknown/not applicable then enter '99:99'	Time the patient left the originating hospital if a transfer patient.	W
6	ED Discharge Date	X	X		EDDischargeDate	Xs:date	No	R	Must be a valid date format (CCYYMMDD). If date is unknown/not applicable then enter '99999999'	Filler changed back to ED discharge date	B
7	Ed Discharge Time	X	X		EDDischarg	Xs:time	No	R	Collected	Filler changed	W

					eTime				asHH:MM military time. Must range from 00:00 to 23:59 If time is unknown/not applicable then enter '99:99'	back to ED discharge time	
8	ED/Hospital Arrival Date	X	X	Yes	HospitalArrivalDate	Xs:date	no	R	Must be a valid date format (CCYYMMDD). ED/HospitalArrival Date cannot be earlier than EMSDispatch Date. ED/HospitalArrival Date cannot be earlier than EMS Unit Arrival on SceneDate. ED/HospitalAr	Ifthe patient was brought to the ED, enter date patientarrived at ED. If patient wasdirectly admitted to the hospital, enter date patientwas admitted to the hospital.	A

									rival Date cannot be earlier than EMSUnit Scene Departure Date. ED/HospitalArrival Date cannot be later than ED DischargeDate. ED/HospitalArrival Date cannot belater than HospitalDischarge Date. ED/HospitalArrival Date cannot be earlier than Date of Birth. ED/HospitalArrival Datecannot beprior to 1993.		

									ED/HospitalArrival Dateminus Injury Incident Dateshould be less than 30 days ED/HospitalArrival Dateminus EMS Dispatch Date cannot be greater than 7 days		
9	ED/Hospital Arrival Time	X	X	Yes	HospitalArrivalTime	Xs:time	no	R	Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99' ED/HospitalArrival Time cannot be earlier than	The time the patient arrived to the ED/Hospital. If the patient was brought to the ED, enter time patient arrived at ED. If patient was directly admitted to the hospital, enter time patient was admitted to the hospital.	W

									EMS Dispatch Time. ED/HospitalArrival Time cannot be earlier than EMS Unit Arrival on Scene Time. ED/HospitalArrival Time cannot be earlier than EMS Unit Scene Departure Time. ED/HospitalArrival Time cannot be later than ED Discharge Time. ED/HospitalArrival Time cannot be later than Hospital Discharge Time.		

10	Medical Record Number	X	X	No	MedicalRecordNumber	Xs:string	No	R	Must be present.	Patient's hospital Medical Record Number	A
11	Social Security Number	X	X	No	PatientId	Xs:string	No	R	Must be present if known. Must be numeric. Must be a valid social security number or '000000001' if Unknown	Patient's Social Security Number	A
12	Date of Birth	X	X	Yes	DateOfBirth	Xs:date	no	R	Must be present. Must be a valid date format (CCYYMMDD). If date is unknown then enter '99999999'. If Date of Birth is "Not	Patient's Date of Birth	A

									Known/Not Recorded" leave empty and complete variables: Age and AgeUnits. If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed. Field should not be Not Known/Not Recorded. Date of Birth cannot be later than EMS Dispatch Date. Date of Birth cannot be later than EMS Unit Arrival on Scene Date. Date of Birth		

									cannot be later than EMS Unit Scene Departure Date. Date of Birth cannot be later than ED/Hospital Arrival Date. Date of Birth cannot be later than ED Discharge Date. Date of Birth cannot be later than Hospital Discharge Date. Date of Birth + 120 years must be less than ED/Hospital Arrival Date. Field cannot be Not Applicable.		

13	Gender	X	X	Yes	Sex	Xs:integer	no	R	Must be present. Must be 1-Male, 2-Female.	Patient Gender. Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment.	A
14	Patient Zip Code	X	X	Yes	HomeZip	Xs:string	No	C	Must be present unless Patient Country is not the United States. Must be numeric. Must be a valid postal code. If patient zip code is unknown then enter '999999999'. If patient zip code is a foreign zip	The patient's home ZIP code of primary residence. 4-Digit zip code extension can be applied. May require adherence to HIPAA regulations.	A

									code and unknown then enter ‘888888888’. If ZIP/Postal code is "Unknown," record UNK and complete variable: Alternate Home Residence. If ZIP/Postal code is "NotKnown/Not Recorded," record UNK and complete variables: Patient's Home Country, Patient's Home State (USonly), Patient's Home County (US only) and Patient's Home City (US		

									only).		
15	Injury Incident Date	X	X	Yes	IncidentDate	Xs:date	No	R	Must be present. Must be a valid date format (CCYYMMDD). InjuryIncident Date cannot be earlier than Date of Birth. InjuryIncident Date cannot be later than EMS Dispatch Date. InjuryIncident Date cannot be later than EMS Unit Arrival on SceneDate. InjuryIncident Date cannot be later than EMS Unit Scene	The date the injury occurred. Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used. For partial date entries see Common Null Value page 12	A

									Departure Date. InjuryIncident Date cannot be later than ED/Hospital Arrival Date. InjuryIncident Date cannot be later than ED Discharge Date. InjuryIncident Date cannot be later than HospitalDischargeDate.		
16	Injury Incident Time	X	X	Yes	IncidentTime	Xs:time	No	R	Must be present. Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not	The time the injury occurred. Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures	W

									applicable then enter '99:99' InjuryIncidentTime cannot be later than EMS Dispatch Time. InjuryIncidentTime cannot be later than EMS Unit Arrival on Scene Time. InjuryIncidentTime cannot be later than EMS Unit Scene Departure Time. InjuryIncidentTime cannot be later than ED/Hospital Arrival Time. InjuryIncidentTime cannot be later than ED Discharge Time.	(e.g., 911 call time) should not be used.	

									InjuryIncidentTime cannot be later than Hospital Discharge Time.		
17	Work-related	X	X	Yes	WorkRelated	Xs:integer	No	R	Must be a 1, 2, or 9. Work-Related should be 1 (Yes) when Patient's Occupation is not: (1) blank, (2) Not Applicable, or(3) Not Known/Not Recorded. Work-Relatedshould be 1 (Yes) when Patient's Occupational Industry is not: (1) blank, (2)NotApplicable,or (3) Not Known/NotRec	Indication of whether the injury occurred during paid employment. 1 = Yes 2 = No 9=UNK	A

									orded.		
18	Patient Street Address	X	X	No	PatientStreetAddress	Xs:string	No	R	Must be present. If patients are not classified as homeless, migrant workers, or undocumented citizen then address is unknown enter 'UNK'. If patients are classified as homeless, migrant workers, or undocumented citizen then address is not applicable enter 'NA' and fill out Alternate Home Residence.	The patient's home street address.	A
19	Incident City	X	X	Yes	IncidentCity	Xs:string	No	R	Must be present and must be the text value of the Incident	The city or township where the patient was found or to which the unit	W

									City name when Incident Location ZIP/Postal code is not entered. If Incident City is unknown then enter 'UNK'.	responded (or best approximation). Only completed when Incident LocationZIP/Postal code is "Not Applicable" or "Not Known/Not Recorded", and country is US. Used to calculate FIPScode. If incident location resides outside of formal city boundaries, report nearest city/town.	
20	Alcohol Use Indicator	X		Yes	AlcoholUse Indicators	Xs:integer	No	C	May be present. If present must be coded as:	Use of alcohol by the patient. Blood alcohol concentration (BAC) may be	A

									1. No (not tested) 2. No (confirmed by test) 3. Yes (confirmed by test [trace levels]) 4. Yes (confirmed by test [beyond legal limit]) 5. Ifalcohol use is suspected but not confirmed by test.	documented at any facility,unit, or setting treatingthis patient event. "Trace levels"is defined asany alcohol level below the legal limit but not zero. "Beyond legallimit" is defined as a blood alcohol concentration above the legal limitfor the state in which the treating institution is located.above any legal limit, DUI,DWI or DWAI, would apply here. Ifalcohol use is suspected,but not confirmed by test,record 5 - "Not Known/Not Recorded."	

21	Drug Use Indicators	X		Yes	DrugUseIndicator	Xs:Integer	YES: Max 2	C	May be present. 1. No (not tested) 2. No (confirmed by test) 3. Yes (confirmed by test [prescription drug]) 4. Yes (confirmed by test [illegal use drug]) 5. Ifdruguse is suspected,but not confirmed by test.	Use of drugs by the patient. Drug use may be documented at any facility, unit or setting treating this patientevent. "Illegal use drug" includes illegal use of prescription drugs. Thisdata element refers to drug use by the patient and does not include medical treatment. Ifdrug use is suspected, but not confirmed by test, record 5 - "Not Known/Not Recorded."	A

22	Patient City	X	X	Yes	HomeCity	Xs:string	No	R	Must be present and must be the text value of the Patient's Home City name when Patient's ZIP/Postal code is not entered. If patient city is unknown then enter 'UNK'.	The patient's city (or township, or village) of residence. Only completed when ZIP/Postal code is "Not Known/Not Recorded" and countryExternal is US.	A
24	Initial Glasgow Eye Component in ED	X		Yes	GcsEye	Xs:integer	no	C	Must be coded as: 1. No eye movement whenassessed 2. Opens eyes in responseto painful stimulation 3. Opens eyes in responseto verbal stimulation	First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival. Used to calculate Overall GCS - ED Score. Ifa patient does not have anumeric GCSscore	A

									4. Opens eyes spontaneously	recorded, but written documentation closely (or directly) relates to verbiage describing a specific level offunctioning within the GCS scale, the appropriate numeric scoremay be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 maybe recorded, IF there is no other contradicting documentation. Please note that first recorded/hospitalvitals do not need to be	

										from the same assessment.	
25	Initial Glasgow Verbal Component in ED	X		Yes	GcsVerbal	Xs:integer	No	C	Must be coded as: Pediatric (<= 2 Years) 1.No Vocal Response 2. Inconsolable, agitated 3. Inconsistentlyconsolable, moaning 4. Cries but isconsolable, inappropriate interactions 5. Smiles, oriented to sounds, follow objects, interacts Adult 1. No verbal response 2. Incomprehensi	First recorded Glasgow Coma Score (Verbal) within 30 minutes or less of ED/hospital arrival. Used to calculate Overall GCS - ED Score Ifpatient is intubated then the GCS Verbal scoreis equal to 1. Ifa patient does not have anumeric GCSscore recorded, but written documentation closely (or directly) relates to verbiage describing a specific level	A

									ble sounds 3. Inappropriate words 4. Confused 5. Oriented	offunctioning within the GCS scale, the appropriate numeric scoremay be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 maybe recorded, IF there is no other contradicting documentation. Please note that first recorded/hospitalvitals do not need to be from the same assessment.	
26	Initial Glasgow Motor Component in ED	X		Yes	GcsMotor	Xs:integer	No	C	Must be coded as: Pediatric (<= 2 Years)	First recorded Glasgow Coma Score (Motor) within30 minutes or less of ED/hospital	A

									1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localizing pain 6. Appropriate response tostimulation Adult 1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localizing pain 6. Obeys commands	arrival. Used to calculate Overall GCS – ED Score. If a patient does not have anumeric GCSscore recorded, but written documentation closely (or directly) relates to verbiage describing a specific level offunctioning within the GCS scale, the appropriate numeric scoremay be listed.E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 maybe	

										recorded, IF there is no other contradicting documentation. Please note that first recorded/hospitalvitals do not need to be from the same assessment.	
27	Glasgow Coma Score Total in the ED	X		Yes	TotalGcs	Xs:integer	No	C	May be present. If present must be numeric and must be the sum of Eye, Verbal and Motor.	First recorded Glasgow Coma Score (total) within 30 minutes or less of ED/hospital arrival. If a patient doesnot have anumeric GCSrecorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake	A

										alertand oriented,"or "patient with normal mental status,"interpret this as GCS of 15 IF there is no other contradicting documentation. Please note that first recorded/hospitalvitals do not need to be from the same assessment. Sum of Eye, Verbal, and Motor valid 2 digit score should add up to the total. Do not include unknown or not applicable code in summation.	
28	Glasgow Coma Score Assessment Qualifier in the ED	X		Yes	GcsQualifier	Xs:integer	Yes Max 3	C	May be present. If present	Documentation of factors potentially affecting the	A

									must be coded as: 1. Patient Chemically Sedated or Paralyzed 2. Obstruction to the Patient's Eye 3. Patient Intubated 4. Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye	first assessmentof GCS within 30 minutes or less of ED/hospital arrival. Identifies treatments given to the patient that may affectthe first assessment ofGCS. This field does not applyto self-medications the patient mayadminister (i.e., ETOH, prescriptions, etc.). Ifan intubated patient has recently received an agentthat results in neuromuscular blockadesuch that a motor or eyeresponse is	

										notpossible,then the patient should beconsidered to have an exam that is not reflective of their neurologic statusand the chemical sedation modifier should be selected. Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium,rocuronium, (cis)atracurium, vecuronium,or pancuronium.While these are themost common agents, please reviewwhat might be	

										typically used in your center so it can be identified in the medical record. Each of these agents has aslightly different duration ofaction, so their effect on the GCSdepends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes. Please note that first recorded/hospitalvitals do not need to be from the same assessment.	
29	Respiration Rate	X	X	Yes	Respiratory Rate	Xs:integer	No	R	Must be present.	First recorded respiratory rate in the	W

									Must be numeric. 888 = Not Recorded 999 = Unknown Cannot be> 99 for age in years >= 6 OR RR cannot be > 120 for age in years< 6. Ifage and age units are not valued, RR cannot be> 120 Cannot be>99 and <=120for age in years < 6. Ifage and age units are not valued, RR cannot be > 99	ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute). Ifavailable, complete additional field:Initial ED/Hospital RespiratoryAssistance. Please note that first recorded/hospitalvitals do not need to be from the same assessment.	
30	Blood Pressure	X	X	Yes	Sbp	Xs:integer	No	R	Must be present.	First recorded systolic blood pressure in the	W

									Must be numeric. Must be between 0 and 299. 888 = Not Recorded 999 = Unknown	ED/hospital within 30minutes or less of ED/hospital arrival. Please note that first recorded/hospitalvitals do not need to be from the same assessment. Measurementrecorded must be without the assistance of CPR oranytype of mechanical chest compressiondevice. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions	

										are paused.	
31	Pulse Rate	X	X	Yes	PulseRate	Xs:integer	No	R	Must be present. Must be numeric. Must be between 0 and 299. 888 = Not Recorded 999 = Unknown	First recorded pulse in theED/hospital (palpated or auscultated) within 30 minutes or less of ED/hospital arrival (expressed as a number per minute). Please note that first recorded/hospitalvitals do not need to be from the same assessment. Measurementrecorded must be without the assistance of CPR oranytype of mechanical chest compressiondevice. For those patients who	W

										are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.	
32	Incident State	X	X	Yes	IncidentState	Xs:string	No	R	Must be present and must be a valid 2-digit postal state code as found in Table 2.	The state, territory, or province where the patient was found or to which the unitresponded (orbest approximation). Only completed when Incident LocationZIP/Postal code is "Not Applicable" or "Not Known/Not Recorded", and country isUS. Used to calculate FIPScode.	W

33	Transport Mode	X	X	Yes	Transport Mode	Xs:string	No	R	Must be present. When present must be coded as: 1. Ground Ambulance 2. Helicopter Ambulance 3. Fixed-wingAmbulance 4. Private/Public Vehicle/Walk-in 5. Police 6. Other 9. Unknown	The mode of transport delivering the patient to your hospital.	B
34	DPH Facility ID Number	X	X	No	DPHFacility IDNumber	Xs:string	No		Must be valid code from table 1.	A number assigned by the Department of Public Health to identify the facility.	B

35	Service Level	X		No	ServiceLevel	Xs:integer	No		Must be coded as: 1 - Outpatient Emergency Department Stay 2- Outpatient Observation Stay 3 – Inpatient Stay 4 - Death on Arrival	The highest level of service provided in the hospital setting. Code values 1-4.	B
36	Patient Home Country	X	X	Yes	PatientHomeCountry	Xs:string	No	C	2 digit alpha country code. If patient home country unknown or not applicable then enter 'NA'. If Patient's Home Country is not US, then the null value "Not Applicable" is used for: Patient's Home State,	The country where the patient resides. Relevant value for data element (two digit alpha country code) Values are two character FIPS codes representing the country (e.g.,US). If Patient's	B

									Patient's Home County, and Patient's Home City.	Home Country is not US, then the null value "Not Applicable" is used for: Patient's Home State, Patient's Home County,and Patient's Home City.	
37	Patient Home County	X	X	Yes	PatientHomeCounty	Xs:integer	No	C	Must be a 3 digit numeric FIPS code.	The patient's county(or parish) of residence. Relevant value for data element (three digit numeric FIPS code). Only completed when ZIP/Postal code is "Not Known/Not Recorded" and country is US. Used to calculate FIPS	B

										code.	
38	Alternate Home Residence	X	X	Yes	AlternateHomeResidence	Xs:String	No	C	Must be coded as: 1 – Homeless 2 – Undocumented Citizen 3 – Migrant worker	Documentation of the type of patient without a home ZIP/Postal code. Only completed when ZIP/Postal code is "Unknown." Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters. Undocumented Citizen is defined as a national of	B

										another country who has entered or stayed in another country without permission. Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.	
39	Age	X	X	Yes	Age	Xs:integer	No	R	Age must be within the valid range of 0 – 120. Injury Date minus Date of Birth should equal	The patient's age at the time of injury (best approximation). Used to calculate patient age in minutes, hours,	B

									submitted Age as expressed in the Age Units specified. Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days,24 months, or 120 years. Please verify this is correct. Field must be Not Applicable when Age Units is Not Applicable. Field must be Not Known/Not Recorded when Age Units is Not Known/Not	days, months, or years. If Date of Birth is "Not Known/Not Recorded", complete variables: Age and Age Units. If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed. Must also complete variable: Age Units. Must be less than or equal to 120.	

									Recorded.		
40	Age Units	X	X	Yes	AgeUnits	Xs:integer	No	R	Must be coded as: 1 – Hours 2 - Days 3 – Months 4 – Years 5 - Minutes Field must be Not Applicable when Age is Not Applicable. Field must be Not Known/Not Recorded when Age is Not Known/Not Recorded.	The units used to document the patient's age (Minutes, Hours, Days, Months, Years). Used to calculate patient age in minutes, hours, days, months, or years. If Date of Birth is "Not Known/Not Recorded", complete variables: Age and Age Units. If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed.	B

										Must also complete variable: Age.	
41	Ethnicity	X	X	Yes	Ethnicity	Xs:integer	No	R	Must be coded as: 1. Hispanic or Latino 2. Not Hispanic or Latino 9. Unknown	The patient's ethnicity. Patient ethnicity should be based upon self-report or identified by a family member.	B
42	Patient Occupational Industry	X		Yes	PatientOccupationalIndustry	Xs:integer	No	C	Must be coded as: 1. Finance, Insurance, and Real Estate 2. Manufacturing 3. Retail Trade 4. Transportation and Public Utilities 5. Agriculture, Forestry,	The occupational industry associated with the patient's work environment. If work related, also complete Patient's Occupation. Based upon US Bureau of Labor Statistics Industry Classification.	B

									Fishing 6. Professional and Business Services 7. Education and Health Services 8. Construction 9. Government 10. Natural Resources and Mining 11. Information Services 12. Wholesale Trade 13. Leisure and Hospitality 14. Other Services 99. Unknown		
43	Patient Occupation	X	X	Yes	PatientOccupation	Xs:integer	No	C	Must code as: 1. Business and Financial Operations Occupations 2. Architecture	The occupation of the patient. Only completed if injury is work-related.	B

									and Engineering Occupations 3. Community and Social Services Occupations 4. Education, Training, and Library Occupations 5. Healthcare Practitioners and Technical Occupations 6. Protective Service Occupations 7. Building and Grounds Cleaning and Maintenance 8. Sales and Related Occupations 9. Farming, Fishing, and Forestry Occupations 10. Installation, Maintenance, and Repair	If work related, also complete Patient's Occupational Industry. Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).	

									Occupations 11. Transportation and Material Moving Occupations 12. Management Occupations 13. Computer and Mathematical Occupations 14. Life, Physical, and Social Science Occupations 15. Legal Occupations 16. Arts, Design, Entertainment, Sports ,and Media 17. Healthcare Support Occupations 18. Food Preparation and Serving Related 19. Personal Care and		

									Service Occupations 20. Office and Administrative Support Occupations 21. Construction and Extraction Occupations 22. Production Occupations 23. Military Specific Occupations 99. Unknown		
44	ICD10 Primary External Cause Code	X	X	Yes	ICD10PrimaryExternalCauseCode	Xs:string	No	R	Must be present. Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84 with exclusion criteria listed below. Exclude Y90.XXX -	RelevantICD-10-CMcode value for injuryevent The primaryexternal cause code should describe the main reason a patient is admitted to the hospital. External cause codes are used to auto-generate two calculated	W

									Y99.XXX, and Z00.XXX – Z99.XXX as they are not valid for Primary code.	fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix). ICD-10-CM codes will be accepted for this data element. Activity codes should notbe reported in this field. Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84 with exclusion criteria listed below. Exclude Y90.XXX - Y99.XXX, and Z00.XXX – Z99.XXX as they are not valid for Primary code.	

45	ICD10 Place of Occurrence External Cause Code	X	X	Yes	ICD10PlaceofOccurrenceExternalCauseCode	Xs:string	No	R	Must be a valid value (ICD-10 CM only). Place of Injury code should be Y92.X/Y92.XX/ Y92.XXX(where X is A-Z [excluding I,O]or 0-9) (ICD-10 CM only). Invalid value (ICD-10 CA only). Place of Injury code should be U98X(where X is 0-9)(ICD-10 CA only).	Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x). RelevantICD-10-CMcode value for injury event. Only ICD-10-CM codes will be accepted for ICD-10 Place of Occurrence External Cause Code. Must be a valid ICD-10-CM code Y92.XXXX 3 to 7 digits/characters long (exclude decimal point).	W
46	Incident Location Postal Code	X	X	Yes	IncidentLocationPostalCode	Xs:string	No	R	Must be a valid Zip/Postal code if	The ZIP/Postal code of the incident location.	B

									Incident Country is US. If incident location postal code is unknown then enter '999999999'. If incident location postal code is a foreign zip code and unknown then enter '888888888'.	Can be stored as a 5 or 9 digit code (XXXXXXXXX) for US and CA, or can be stored in the postal code format of the applicable country. If "Not Applicable" or "Not Known/Not Recorded, "complete variables: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only). May require adherence to HIPAA regulations.	

										If ZIP/Postal code is known, then must complete Incident Country.	
47	Incident Country	X		Yes	IncidentCountry	Xs:string	No	R	Must be a valid 2 character FIPS code. If Incident Country is unknown or not applicable then enter 'NA'. Field cannot be Not Known/Not Recorded when Home Zip is not:(1) blank, (2)Not Applicable, or(3) Not Known/Not Recorded.	The country where the patient was found or to which the unit responded (or best approximation). Relevant value for data element (two digit alpha country code). Values are two character FIPS codes representing the country (e.g.,US). If Incident Country is not US, then the null value "Not	B

										Applicable" is used for: Incident State, Incident County, and Incident City.	
48	Incident County	X		Yes	IncidentCounty	Xs:string	No	R	Must be a valid 3 character FIPS code. Field cannot be Not Applicable. Field must be Not Applicable (Non-US).	The county or parish where the patient was found or to which the unit responded (or best approximation). Relevant value for data element (three digit numeric FIPS code) Only completed when Incident Location ZIP/Postal code is "Not Applicable" or "Not Known/Not Recorded", and country is US. Used to	B

										calculate FIPS code.	
49	Report of Physical Abuse	X	X	Yes	ReportofPhysicalAbuse	Xs:integer	No	R	Must be coded as: 1. Yes 2. No	A report of suspected physical abuse was made to law enforcement and/or protective services. This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse.	W
50	Investigation of Physical Abuse	X		Yes	InvestigationofPhysical Abuse	Xs:integer	No	C	Must be coded as: 1. Yes 2. No Field should not be Not Applicable when Report of Physical Abuse = 1 (Yes).	An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse. This includes, but is not	W

										limited to, a report of child, elder, spouse or intimate partner physical abuse. Only complete when Report of Physical Abuse is 1. Yes. The null value "Not Applicable" should be used for patients where Report of Physical Abuse is 2. No.	
51	Caregiver at Discharge	X		Yes	Caregiverat Discharge	xs:integer	No	C	Must be coded as: 1. Yes 2. No	The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse. Only complete when Report of Physical Abuse is 1. Yes.	W

										Only complete for minors as determined by state/local definition, excluding emancipated minors. The null value "Not Applicable" should be used for patients where Report of Physical Abuse is 2. No or where older than the state/local age definition of a minor. The null value "Not Applicable" should be used if the patient expires prior to discharge.	
52	EMS Dispatch Date	X	X	Yes	EMSDispatchDate	Xs:date	no	R	Must be a valid date	The date the unit	W

									format (CCYYMMDD). If date is unknown/not applicable then enter '99999999'. EMS Dispatch Date cannot be earlier than Date of Birth EMS Dispatch Date cannot be later than EMS Unit Arrival on Scene Date. EMS Dispatch Date cannot be later than EMS Unit Scene Departure Date. EMS Dispatch Date cannot be later than ED/Hospital	transporting to your hospital was notified by dispatch. Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival). For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport. For patients transported	

									Arrival Date. EMS Dispatch Date cannot be later than ED Discharge Date. EMS Dispatch Date cannot be later than Hospital Discharge Date.	from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.	
53	EMS Dispatch Time	X	X	Yes	EMSDispatchTime	Xs:time	No	R	Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99' EMS Dispatch Time cannot be later than	The time the unit transporting to your hospital was notified by dispatch. Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival).	W

									EMS Unit Arrival on Scene Time. EMS Dispatch Time cannot be later than EMS Unit Scene Departure Time. EMS Dispatch Time cannot be later than ED/Hospital ArrivalTime. EMS Dispatch Time cannot be later than ED Discharge Time. EMS Dispatch Time cannot be later than Hospital Discharge Time.	For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch. For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.	
54	EMS Unit Arrival Date at Scene or Transferring Facility	X	X	Yes	EMSUnitArrivalDateatSceneorTra	Xs:date	No	R	Must be a valid date format	The date the unit transporting to	W

					nsferringFacility				(CCYYMMDD). If date is unknown/not applicable then enter '99999999'. EMS Unit Arrival on Scene Date cannot be earlier than Date of Birth. EMS Unit Arrival on Scene Date cannot be earlier than EMS Dispatch Date. EMS Unit Arrival on Scene Date cannot be later than EMS Unit Scene Departure Date. EMS Unit	your hospital arrived on the scene/transferring facility. Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure). For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived	

									Arrival on Scene Date cannot be later than ED/Hospital Arrival Date. EMS Unit Arrival on Scene Date cannot be later than ED Discharge Date. EMS Unit Arrival on Scene Date cannot be later than Hospital Discharge Date. EMS Unit Arrival on Scene Date minus EMS Dispatch Date cannot be greater than 7 days.	at the transferring facility(arrival is defined at date/time when the vehicle stopped moving). For patients transported from the scene ofinjuryto your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).	

55	EMS Unit Arrival Time at Scene or Transferring Facility	X	X	Yes	EMSUnitArrivalTimeatSceneorTransferringFacility	Xs:time	No	R	Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99'. EMS Unit Arrival on Scene Time cannot be earlier than EMS Dispatch Time. EMS Unit Arrival on Scene Time cannot be later than EMS Unit Scene Departure Time. EMS Unit Arrival on	The time the unit transporting to your hospital arrived on the scene. Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure). For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the	W

									Scene Time cannot be later than ED/Hospital Arrival Time. EMS Unit Arrival on Scene Time cannot be later than ED Discharge Time. EMS Unit Arrival on Scene Time cannot be later than Hospital Discharge Time.	transferring facility arrived at the transferring facility(arrival is defined at date/time when the vehicle stopped moving). For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).	
56	EMS Unit Departure Date from Scene or Transferring Facility	X	X	Yes	EMSUnitDepartureDatefromSceneorTransfe	Xs:date	No	R	Must be a valid date format (CCYYMMDD).	The date the unit transporting to your hospital	W

					rringFacilit y				If date is unknown/not applicable then enter '99999999'. EMS Unit Scene Departure Date cannot be earlier than Date of Birth. EMS Unit Scene Departure Date cannot be earlier than EMS Dispatch Date. EMS Unit Scene Departure Date cannot be earlier than EMS Unit Arrival on Scene Date. EMS Unit Scene	left the scene. Used to auto-generate an additional calculated field: Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure). For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).	

									Departure Date cannot be later than ED/Hospital Arrival Date. EMS Unit Scene Departure Date cannot be later than ED Discharge Date. EMS Unit Scene Departure Date cannot be later than Hospital Discharge Date. EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date cannot be greater than 7 days.	For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).	

57	EMS Unit Departure Time from Scene or Transferring Facility	X	X	Yes	EMSUnitDepartureTimefromSceneorTransferringFacility	Xs:time	No	R	Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99'. EMS Unit Scene Departure Time cannot be earlier than EMS Dispatch Time. EMS Unit Scene Departure Time cannot be earlier than EMS Unit Arrival on Scene Time. EMS Unit Scene	The time the unit transporting to your hospital lef the scene. Used to auto-generate an additional calculated field: Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure). For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at	W

									Departure Time cannot be later than ED/Hospital Arrival Time. EMS Unit Scene Departure Time cannot be later than the ED Discharge Time. EMS Unit Scene Departure Time cannot be later than Hospital Discharge Time.	date/time when the vehicle started moving). For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).	
58	Initial Field systolic blood pressure	X		Yes	InitialFieldsystolicbloodpressure	Xs:integer	No		Must be a 3 digit entry between 0 and 299. If Initial Field Systolic Blood Pressure is Not Known/Not	First recorded systolic blood pressure measured at the scene of injury. The null value "Not	W

									Recorded then enter 'UNK'. If Initial Field Systolic Blood Pressure is Not Applicable then enter 'NA'.	Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused. The null value	

										"Not Applicable" is usedf or patients who arrive by 4.Private/Public Vehicle/Walk-in.	
59	Initial Field Pulse Rate	X		Yes	InitialFieldPulseRate	Xs:integer	No	R	Must be a 3 digit entry between 0 and 299. If Initial Field Pulse Rate is Not Known/Not Recorded then enter 'UNK'. If Initial Field Pulse Rate is Not Applicable then enter 'NA'.	First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. Measurement recorded must be without the	W

										assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
60	Initial Field Respiratory Rate	X		Yes	InitialField Respiratory Rate	Xs:integer	No	R	Must be a 3 digit numeric entry. If Initial Field Respiratory	First recorded respiratory rate measured at the scene of injury (expressed as a	W

									Rate is Not Known/Not Recorded then enter 'UNK'. If Initial Field Respiratory Rate is Not Applicable then enter 'NA'. RR cannot be> 99 for age in years >= 6 OR RR cannot be > 120 for age in years< 6. If age and age units are not valued, RR cannot be> 120. RR cannot be>99 and <=120for age in years < 6. If age and Age units are not valued, RR cannot be > 99.	number per minute). The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	

61	Initial Field Oxygen Saturation	X		Yes	InitialField OxygenSaturation	Xs:integer	No	R	Must be a 3 digit entry and numeric. Must be a value between 0 and 100. If Initial Field Oxygen Saturation is Not Known/Not Recorded then enter 'UNK'. If Initial Field Oxygen Saturation is Not Applicable then enter 'NA'.	First recorded oxygen saturation measured at the scene of injury (expressed as a percentage). The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. Value should be based upon assessment before administration of supplemental oxygen. The null value "Not Applicable" is	W

										used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
62	Initial Field GCS EYE	X		Yes	InitialField GCSEYE	Xs:integer	No	R	Must be present and coded as: 1. No eye movement when assessed 2. Opens eyes in response to painful stimulation 3. Opens eyes in response to verbal stimulation 4. Opens eyes spontaneously	First recorded Glasgow Coma Score (Eye) measured at the scene of injury. Used to calculate Overall GCS - EMS Score. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.	W

										If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. The null value "Not	

										Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
63	Initial Field GCS Verbal	X		Yes	InitialField GCSVerbal	Xs:integer	No	R	Must be present and coded as: Pediatric (<= 2 Years) 1.No Vocal Response 2. Inconsolable, agitated 3. Inconsistently consolable, moaning 4. Cries but is consolable, inappropriate interactions 5. Smiles, oriented to sounds, follow objects, interacts	First recorded Glasgow Coma Score (Verbal) measured at the scene of injury. Used to calculate Overall GCS - EMS Score. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. Ifpatient is	W

									Adult 1. No verbal response 2. Incomprehensible sounds 3. Inappropriate words 4. Confused 5. Oriented	intubated then the GCS Verbal scoreis equal to 1. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 maybe recorded, IF there is no other	

										contradicting documentation. The null value "Not Applicable" is used for patients who arrive by 4.Private/Public Vehicle/Walk-in.	
64	Initial Field GCS Motor	X		Yes	InitialField GCSMotor	Xs:integer	No	R	Must be present and coded as: Pediatric (<= 2 Years) 1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localizing pain 6. Appropriate response to stimulation	First recorded Glasgow Coma Score (Motor) measured at thescene of injury. Used to calculate Overall GCS - EMS Score. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS	W

									Adult 1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localizing pain 6. Obeys commands	Run Report from the scene of injury. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 maybe recorded, IF there is no other contradicting	

										documentation. The null value "Not Applicable" is used for patients who arrive by 4.Private/Public Vehicle/Walk-in.	
65	Initial Field GCS Total	X		Yes	InitialField GCSTotal	Xs:integer	No	R	The GCS Total is outside the valid range of 3 – 15. Initial Field GCS - Total does not equal the sum of Initial Field GCS- Eye, Initial Field GCS- Verbal, and Initial Field GCS – Motor.	First recorded Glasgow Coma Score (total) measured at the scene of injury. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. If a patient does not have a	W

										numeric GCSrecorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented, "or "patient with normal mental status, "interpret this as GCS of 15 IF there is no other contradicting documentation. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
66	Trauma Center Criteria	X		Yes	Traumacentercriteria	Xs:String	No	R	Must be coded as:	Physiologic and anatomic EMS trauma triage	W

									1. Glasgow Coma Score <= 13 2. Systolic blood pressure< 90 mmHg 3. Respiratory rate < 10 or > 29 breaths per minute (<20 in infants aged < 1 year) or need for ventilatory support 4. All penetrating injuries to head, neck, torso, and Extremities proximal to elbow or knee 5. Chest wall instability or deformity(e.g., flail chest)	criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report. The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS. The null value "Not Applicable" should be used if EMSRun	

									6. Two or more proximal long-bone fractures 7. Crushed, degloved, mangled, or pulseless extremity 8. Amputation proximal to wrist or ankle 9. Pelvic fracture 10. Open or depressed skull fracture 11. Paralysis	Report indicates patient did not meet any Trauma Center Criteria. The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.	
67	Vehicular Pedestrian Other Risk Injury	X		Yes	Vehicularpedestrianotherriskinjury	Xs:integer	No	R	Must be coded as: 1. Fall adults:> 20 ft.(one story is equal to 10 ft.) 2. Fall	EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control	W

									children: > 10 ft.or 2-3 times the height of the child 3. Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site 4. Crash ejection (partial or complete) from automobile 5. Crash death in same passenger compartment 6. Crash vehicle telemetry data (AACN) consistent with high risk injury	and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report. The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS. The null value "Not Applicable" should be used if EMSRun Report indicates patient did not meet any Vehicular,Pedestrian, Other	

									7. Auto v. pedestrian/bicyclist thrown, run over, or > 20 MPH impact 8. Motorcycle crash> 20 mph 9. For adults > 65; SBP < 110 10. Patients on anticoagulants and bleeding disorders 11. Pregnancy> 20 weeks 12. EMS provider judgment 13. Burns 14. Burns with Trauma	Risk Injury criteria. The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.	
68	Pre Hospital Cardiac Arrest	X	X	Yes	Prehospital cardiacarre	Xs:integer	No	R	Must be coded as:	Indication of whether	W

					st				1. Yes 2. No	patient experienced cardiac arrest prior to ED/Hospital arrival. A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation. The event must have occurred outside of the reporting hospital, prior to admission at the center in which the registry is maintained. Pre-hospital cardiac arrest could occur at a transferring	

										institution. Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider.	
69	Initial ED Hospital Temperature	X		Yes	InitialEDHospitaltemperature	Xs:string	No	R	Must be a valid 4 digit temperature with decimals included. Temperature cannot exceed the max of 45 Celsius. 99.9 = Unknown 88.8 = Not Recorded / Not Taken	First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival. Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be a valid 4 digit temperature with decimal	B

										included. Temperature cannot exceed the max of 45 Celsius.	
70	Initial ED Hospital Respiratory Assistance	X		Yes	InitialEDHospitalRespiratoryAssistance	Xs:integer	No	R	Must be coded as: 1. Unassisted Respiratory Rate 2. Assisted Respiratory Rate 9. Unknown /Not Taken	Determination ofrespiratory assistanceassociatedwith the initial ED/hospital respiratory rate within 30 minutes or lessof ED/hospital arrival. Complete when Initial ED/Hospital Respiratory Rate is completed. Respiratory Assistance is defined as mechanical and/or external support of respiration.	B

										Please note that first recorded/ do not need to be from the same assessment.	
71	Initial ED Hospital Oxygen Saturation	X		Yes	InitialEDHospitalOxygenSaturation	Xs:integer	No	R	Must be a valid 3 digit entry between 0 and 100. 888 = Not Recorded /Not Taken 999= Unknown	First recorded oxygen saturation in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage). Complete additional field: Initial ED/Hospital Supplemental Oxygen. Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be a valid	B

										3 digit entry between 0 and 100.	
72	Initial ED Hospital Supplemental Oxygen	X		Yes	InitialEDHospitalSupplementalOxygen	Xs:integer	No	R	Must be coded as: 1. No Supplemental Oxygen 2. Supplemental Oxygen 9. NA	Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level within 30minutesor less of ED/hospital arrival. Only completed if a value is provided for Initial ED/Hospital Oxygen Saturation, otherwise report as "Not Applicable". Please note that first recorded/hospi	B

										tal vitals do not need to be from the same assessment. Must be valid 2 digit entry as specified in Field Values.	
73	Initial ED Hospital Height	X		Yes	InitialEDHospitalHeight	Xs:integer	No	R	Must be a 3 digit entry in centimeters, no greater than 244 centimeters. 999 = Unknown	First recorded height upon ED/hospital arrival. Recorded in centimeters. May be based on family or self-report. Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be a valid 3 digit entry in centimeters.	B

										No values greater than 244 centimeters.	
74	Initial ED Hospital Weight	X		Yes	InitialEDHospitalweight	Xs:integer	No	R	Must be a 3 digit entry in kilograms, no greater than 907 kilograms. 999 = Unknown	Measured or estimated baseline weight. Recorded in kilograms. May be based on family or self-report. Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be a valid 3 digit entry in kilograms. No values greater than 907 kilograms.	B
75	ED Discharge Disposition	X	X	Yes	EDDischargeDispositio	Xs:integer	No	R	Must be coded as:	The disposition of the patient	W

					n				1. Floor bed (general admission, non-specialty unit bed) 2. Observation unit (unit that provides < 24 hour stays) 3. Telemetry/step-down unit (less acuity than ICU) 4. Home with services 5. Deceased/expired 6. Other (jail, institutional care, mental health, etc.) 7. Operating Room	at the time of discharge from the ED. The null value "Not Applicable" is used if the patient is directly admitted to the hospital. If ED Discharge Disposition is 4, 5, 6,9, 10, 11, then Hospital Discharge Date, Time, and Disposition should be "Not Applicable".	

									8. Intensive Care Unit (ICU) 9. Home without services 10. Left against medical advice 11. Transferred to another hospital 88. Unknown 99. Not Applicable Field cannot be Not Known/Not Recorded. Field cannot not be Not Applicable when Hospital Discharge Date is Not Applicable.		

									Field cannot not be Not Applicable when Hospital Discharge Date is Not Known/Not Recorded. Field cannot not be Not Applicable when Hospital Discharge Disposition is Not Applicable. Field cannot not be Not Applicable when Hospital Discharge Disposition is Not Known/Not Recorded.		
76	Signs of life	X		Yes	Signsoflife	Xs:integer	No	R	Must be coded as: 1. Arrived with NO signs of life	Indication of whether patient arrived at ED/Hospital with signs of	**B**

									2. Arrived with signs of life 99. Unknown Field should not be Not Known/Not Recorded Field cannot be Not Applicable Field is 1 (Arrived with NO signs of life) when Initial ED/Hospital SBP> 0, Pulse > 0, OR GCS Motor >1. Please verify. Field is 2 (Arrived with signs of life) when Initial ED/Hospital SBP =0,Pulse = 0,	life. A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress.	

									ANDGCS Motor = 1. Please verify.		
77	Total ICU Length of Stay	X		Yes	TotalICULengthofStay	Xs:integer	No	R	Must be a valid 3 digit entry not less than 1 or more than 575. Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date If Total ICU Length of Stay is Not Applicable then enter 'NA'.	The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day. Recorded in full day increments with any partial calendar day counted as a full calendar day. The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart. If any dates are	B

										missing then a LOS cannot be calculated. If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day. At no time should the ICU LOS exceed the Hospital LOS. The null value "Not Applicable" is used if the patient had no ICU days according to the above definition. Must be a valid 3 digit entry not less than 1 or more than 575.	
78	Total Ventilator Days	X		Yes	TotalVentilatorDays	Xs:integer	No	R	Must be a valid 3 digit	The cumulative amount of time	B

									entry not less than 1 or more than 575. Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date. If Total Ventilator Days is Not Applicable then enter 'NA'.	spent on the ventilator. Each partial or full day should be measured as one calendar day. Excludes mechanical ventilation time associated with OR procedures. Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days. Recorded in full day increments with any partial calendar day counted as a full calendar day.	

										The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart. If any dates are missing then a Total Vent Days cannot be calculated. At no time should the Total Vent Days exceed the Hospital LOS. The null value "Not Applicable" is used if the patient was not on the ventilator according to the above definition.	

										Must be a valid 3 digit entry not less than 1 or more than 575.	
79	Hospital Discharge Date	X	X	Yes	HospitalDischargeDate	Xs:date	No	R	Must be a valid date format (CCYYMMDD). If date is unknown/not applicable then enter '99999999'. Hospital Discharge Date cannot be earlier than EMS Dispatch Date. Hospital Discharge Date cannot be earlier than EMS Unit Arrival on Scene Date. Hospital Discharge Date cannot be	The date the order was written for the patient to be discharged from the hospital. Used to auto-generate an additional calculated field: Total Length of Hospital Stay(elapsed time from ED/hospital arrival to hospital discharge). The null value "Not Applicable" is used If ED Discharge Disposition = 5 Deceased/Expired.	B

									earlier than EMS Unit Scene Departure Date. Hospital Discharge Date cannot be earlier than ED/Hospital Arrival Date Hospital Discharge Date cannot be earlier than ED Discharge Date. Hospital Discharge Date cannot be earlier than Date of Birth Field must be Not Applicable when ED Discharge Disposition= 4,6,9,10, or 11.	The null value "Not Applicable" is used If ED Discharge Disposition = 4,6,9,10, or 11. If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Date is the date of death as indicated on the patient's death certificate.	

									Field must be Not Applicable when ED Discharge Disposition= 5 (Died).		
80	Hospital Discharge Time	X		Yes	HospitalDischargeTime	Xs:time	No	C	Collected as HH:MM military time from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99'. Hospital Discharge Time cannot be earlier than EMS Dispatch Time. Hospital Discharge Time cannot be earlier than EMS Unit	The time the order was written for the patient to be discharged from the hospital. Used to auto-generate an additional calculated field: Total Length of Hospital Stay(elapsed time from ED/hospital arrival to hospital discharge). The null value "Not Applicable" is	W

									Arrival on Scene Time. Hospital Discharge Time cannot be earlier than EMS Unit Scene Departure Time. Hospital Discharge Time cannot be earlier than ED/Hospital Arrival Time. Hospital Discharge Time cannot be earlier than ED Discharge Time. Field must be Not Applicable when ED Discharge Disposition= 4,6,9,10, or 11.	used If ED Discharge Disposition = 5 (Deceased/expired). The null value "Not Applicable" is usedIf ED Discharge Disposition = 4,6,9,10, or 11. IfHospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Time is the time of death as indicated on the patient's death certificate.	

									Field must be Not Applicable when ED Discharge Disposition= 5 (Died).		
81	Hospital Discharge Disposition	X	X	Yes	HospitalDischargeDisposition	Xs:integer	No	R	Must be coded as: 1. Discharged/Transferred to a short-term generalhospital for inpatient care 2. Discharged/Transferred to an Intermediate Care Facility (ICF) 3. Discharge/Transferred to home under care of organized home health	The disposition of the patient when discharged from the hospital. Field value = 6,"home" refers to the patient's current place of residence (e.g., prison, Child Protective Services etc.) Field values based upon UB-04 disposition coding. Disposition to any other non-medical facility should be coded as 6.	B

									service 4. Left against medical advice or discontinued care 5. Deceased/expired 6. Discharged to home or self-care (routine discharge) 7. Discharged/Transferred to Skilled Nursing Facility (SNF) 8. Discharged/ Transferred to hospice care 10. Discharged/Transferred to court/law enforcement.	Disposition to any other medical facility should be coded as 14. The null value "Not Applicable" is usedIf ED Discharge Disposition = 5 (Deceased/expired). The null value "Not Applicable" is usedIf ED Discharge Disposition = 4,6,9,10, or 11.	

									11. Discharged/Transferred to inpatient rehab or designated unit 12. Discharged/Transferred to Long Term Care Hospital (LTCH) 13. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 14. Discharged/Transferred to another type of institution not defined elsewhere		

									99. Not Applicable Field must be Not Applicable when ED Discharge Disposition= 5 (Died). Field must be Not Applicable when ED Discharge Disposition= 4,6,9,10, or 11. Field cannotb e Not Known/Not Recorded when Hospital Arrival Date and Hospital Discharge Date are not:(1)blank, (2) Not Applicable, or (3) Not Known/Not Recorded.		

82	Primary Method of Payment	X	X	Yes	PrimaryMethodofPayment	Xs:integer	No	R	Must be coded as: 1. Medicaid 2. Not Billed (for any reason) 3. Self-Pay 4. Private/Commercial Insurance 6. Medicare 7. Other Government 10. Other 99. Not Applicable / Unknown	Primary source of payment for hospital care. No Fault Automobile, Workers Compensation, and Blue Cross/BlueShield should be captured as Private/Commercial Insurance.	B
83	Race1	X	X	Yes	Race1	Xs:integer	No	R	Must be coded as: 1. Asian 2. Native	The patient's race. Patient race should be based upon	B

									Hawaiian or Other Pacific Islander 3. Other Race 4. American Indian 5. Black or African American 6. White 9. Unknown	self-report or identified by a family member.	
84	Race2	X	X	Yes	Race2	Xs:integer	No	R	Must be coded as: 1. Asian 2. Native Hawaiian or Other Pacific Islander 3. Other Race 4. American Indian 5. Black or African	The patient's race. Patient race should be based upon self-report or identified by a family member.	B

									American 6. White 9. Unknown		
85	OtherTransportMode	X		Yes	OtherTransportMode	Xs:integer	Yes Max 5	C	When present must be coded as: 1. Ground Ambulance 2. Helicopter Ambulance 3. Fixed-wing Ambulance 4. Private/Public Vehicle/Walk-in 5. Police 6. Other	All other modes of transport used during patient care event (prior to arrival at your hospital),except the mode delivering the patient to the hospital. Include in "Other" unspecified modes of transport.	B
86	Injury Diagnosis	X	X	Yes	InjuryDiagnoses	Xs:string	Yes max 50.	R	Must be a valid value (ICD-10 CM only).	Diagnoses related to all identified injuries. Injury diagnoses as	A

										defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28, T30-T32, T79.A1 – T79.A19, T79.A2 - T79.A29, T75.1 and T71. At least one code needs to meet the inclusion criteria as primary or principle code. The primary or principle code must be located in the first diagnostic data field for the record to be included in the submission. ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this field.	

										These codes reside in the diagnostic data fields after the first diagnostic data field. If the other medical conditions are coded in the in the first diagnostic data field, the record will cause a submission error. Used to auto-generate additional calculated fields: Abbreviated Injury Scale (six body regions) and Injury Severity Score. Must be valid up to 7 digit ICD-10-CM code (exclude decimal point).	
87	AIS	X		No	AIS	Xs:String	Yes	R	Must be present.	The Abbreviated	W

									Must be a valid AIS code. Must consist of 6 numbers followed by a decimal point followed by 1 number. The number following the decimal point must be coded as: 1. Minor Injury 2. Moderate Injury 3. Serious Injury 4. Severe Injury 5. Critical Injury 6. Maximum Injury, Virtually Un	Injury Scale (AIS) Pre Dot codes that reflect the patient's injuries. The pre dot code is the 6 digits preceding the decimal point in an associated AIS code. The severity code is the value after the decimal. The Abbreviated Injury Scale (AIS) severity codes that reflect the patient's injuries. The field value (9)"Not Possible to Assign" would be chosen if it is not possible to	

									survivable 9. Not Possible to Assign If predot and/or severity are not able to be coded then enter '999999.9'	assign a severity to an injury.	
88	AIS Version	X		No	AISVersion	Xs:integer	Yes	R	Must be present. Must be 08. To represent AIS05.	The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes.	W
89	ICD-9-CM Diagnosis Code	X	X	Yes	ICD9CMDiagnosisCode	Xs:String	Yes	R	Must be present. Must be valid ICD-9-CM code. (exclude decimal point).	Patient Diagnosis Code	A
90	Protective Devices	X		Yes	Protective Devices	Xs:integer	Yes unlimited.	R	Must be present. Must be	Protective devices (safety equipment) in use or worn by	W

									numeric. Must be coded as: 1. None 2. Lap Belt 3. Personal Floatation Device 4. Protective Non-Clothing Gear (e.g., shin guard) 5. Eye Protection 6. Child Restraint (booster seat or child car seat) 7. Helmet (e.g., bicycle, skiing, motorcycle) 8. Airbag Present	the patient at the time of the injury. If" Child Restraint" is present, complete variable "Child Specific Restraint." If" Airbag" is present, complete variable" Airbag Deployment." Evidence of the use of safety equipment may be reported or observed. Lap Belt should be used to include those patients that are restrained,but not further specified.	

									9. Protective Clothing (e.g., padded leather pants) 10.Shoulder Belt 11. Other 88. Not Recorded 99. Unknown Protective Device should be 6 (Child Restraint) when Child Specific Restraint is not: (1) blank, (2)Not Applicable, or (3) Not Known/Not Recorded. Protective Device should be 8 (Airbag Present) when	Ifchart indicates "3-point-restraint",choose 2. Lap Beltand 10. Shoulder Belt.	

									Airbag Deployment is not:(1) blank, (2)Not Applicable, or (3) Not Known/Not Recorded.		
91	Child Specific restraint	X		Yes	ChildSpecificRestraint	Xs:integer	Yes	C	Must be present if Protective Devices = 6 (Child Restraint). Must be coded as: 1. Child Car Seat 2. Infant Car Seat 3. Child Booster Seat	Protective child restraint device used by patient at the time of injury. Evidence of the use of child restraint maybe reported or observed. Only completed when Protective Devices include "Child Restraint." Or if Protective Devices = 6 (Child Restraint) in one field.	A
92	Airbag Deployment	X		Yes	AirbagDeployment	Xs:integer	Yes	C	Must be present if	Evidence of the use of airbag	A

									Protective Devices = 8 (Airbag). Must be coded as: 1. Airbag Not Deployed 2. Airbag Deployed Front 3. Airbag Deployed Side 4. Airbag Deployed Other (knee, air belt, curtain, etc.) 8. Not Applicable 9. Unknown	deployment maybe reported or observed. Only completed when Protective Devices include "Airbag." Or if Protective Devices = 8 (Airbag) in one field. Airbag Deployed Front should be used for patients with documented airbag deployments, but are not further specified.	
93	Co-Morbid Condition	X		Yes	ComorbidConditions	Xs:integer	Yes Max 5	R	Must be present. Must be coded	Pre-existing co-morbid factors present before patient arrival	W

									as: 0 Not Applicable 1. Other 2. Alcohol Use Disorder 4. Bleeding disorder 5. Currently receiving chemotherapy for cancer 6. Congenital anomalies 7. Congestive heart failure 8. Current smoker 9. Chronic renal failure 10. Cerebrovascular Accident (CVA) 11. Diabetes mellitus	at the ED/hospital. The value of 0 "Not Applicable" is used for patients with no known co-morbid conditions.	

									12. Disseminated cancer 13. Advanced directive limiting care 15. Functionally dependent health status 16. History of angina within30 days 17. History of myocardial infarction 18. History of Peripheral Vascular Disease (PVD) 19. Hypertension requiring medication 21. Prematurity 23. Chronic		

									Obstructive Pulmonary Disease (COPD) 24. Steroid use 25. Cirrhosis 26. Dementia 27. Major psychiatric illness 28. Drug use disorder 30. Attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD)		
94	Complication	X		Yes	HospitalComplication	Xs:integer	Yes Max 10	R	Must be present if Record Type 50 is present. Must be coded as: 0 Not Applicable 1. Other	Any medical complication that occurred during the patient's stay at your hospital. The value of 0 for "Not Applicable" should be used	W

									4. Acute kidney injury 5. Adult respiratory distress syndrome (ARDS) 8. Cardiac arrest with CPR 11. Decubitusulcer 12. Deep surgical site infection 13. Drug or alcohol withdrawal syndrome 14. Deep vein thrombosis(DVT) 15. Extremity compartment syndrome 18. Myocardial infarction 19. Organ/space surgical site infection 21. Pulmonary	for patients with no complications. For any Hospital Complication to be valid, there must be a diagnosis noted in the patient medical record that meets the definition noted in Appendix 3:Glossary of Terms. For all Hospital Complications that follow the CDC definition [e.g., VAP,CAUTI, CLABSI, Osteomyelitis] always use the most recent definition provided by the CDC.	

									embolism 22. Stroke / CVA 23. Superficial surgical site infection 25. Unplanned intubation 29. Osteomyelitis 30. Unplanned return to the OR 31. Unplanned admission to the ICU 32. Severe sepsis 33. Catheter-associated urinary tract infection (CAUTI) 34. Central line-associated bloodstream infection (CLABSI) 35. Ventilator-associated pneumonia (VAP)		

95	ICD10 Hospital Procedure Code	X		Yes	ICD10HospitalProcedureCode	Xs:string	Yes Max 200.	R	Must be present if Record Type 60 is present. Must be a valid value (ICD-10 CMonly). Procedures with the same code cannot have the same Hospital Procedure Start Date and Time.	Major and minor procedure ICD-10-CMprocedurecodes. Include only procedures performed at your institution. Capture all procedures performed in the operating room. Capture all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.	W

										Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one. Note that the hospital may capture additional procedures.	
96	Hospital Procedures Start Date	X		No	HospitalProcedureStartDate	Xs:date	Yes	R	Must be a valid date format (CCYYMMDD). Hospital Procedure Start Date	The date operative and selected non-operative procedures were performed.	W

									cannot be earlier than EMS Dispatch Date. Hospital Procedure Start Date cannot be earlier than EMS Unit Arrival on Scene Date. Hospital Procedure Start Date cannot be earlier than EMS Unit Scene Departure Date. Hospital Procedure Start Date cannot be earlier than ED/Hospital Arrival Date. Hospital		

									Procedure Start Date cannot be later than Hospital Discharge Date. Hospital Procedure Start Date cannot be earlier than Date of Birth.		
97	Hospital Procedures Start Time	X			HospitalProcedureStartTime	Xs:time	Yes	R	Collected as HH:MM military time between 00:00 to 23:59. Hospital Procedure Start Time cannot be earlier than EMS Dispatch Time. Hospital Procedure Start Time cannot be	The time operative and selected non-operative procedures were performed. Procedure start time is defined as the time the incision was made(or the procedure started). If distinct procedures with the same	W

									earlier than EMS Unit Arrival on Scene Time. Hospital Procedure Start Time cannot be earlier than EMS Unit Scene Departure Time. Hospital Procedure Start Time cannot be earlier than ED/Hospital Arrival Time. Hospital Procedure Start Time cannot be later than Hospital Discharge Time.	procedure code are performed, their start times must be different.	

98	Additional ICD10 External Cause Code	X		Yes	AdditionalICD10ExternalCauseCode	Xs:string	Yes Max 50.	R	E-Code is not a valid ICD-10-CM code (ICD-10CM only). Additional External Cause Code ICD-10 should not be equal to Primary External Cause Code ICD-10. E-Code is not a valid ICD-10-CAcode (ICD-10 CA only). V00-Y38, Y62-Y84, Y90-Y99, Z00-Z99	Should not be the same as the Primary External Cause Code. RelevantICD-10-CMcode value for injury event. External cause codes are used to auto-generate two calculated fields: Trauma Type: (Blunt, Penetrating, Burn) and Intentionality(based upon CDC matrix). Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code. Activity codes should not be	W

										reported in this field. Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long (exclude decimal point) V00-Y38, Y62-Y84, Y90-Y99, Z00-Z99	
99	Primary Ecode ICD-9-CM	X	X	Yes	PrimaryEcodeICD9CM	Xs:string	No	R	Must be present. Must be a valid ICD-9-CM Ecode. (exclude decimal point) E800 through E999. Exclude E849.0 – E849.9, E869.4, E870 – E879, E930 – E949 and E967 as they are not valid for Primary ECode.	ECode used to describe the mechanism (or external factor) that caused the injury event. (If two or more events cause separate injuries, an E code should be assigned for each cause. The first-listed E code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm. A code for the ICD-9-CM	W

										external cause of injury that permits classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.)	
100	Location Ecode ICD-9-CM	x	x	Yes	LocationEcodeICD9CM	Xs:string	No	R	Must be present. Must be a valid ICD-9-CM Ecode 849.X (exclude decimal point.	E-code used to describe the place/site/location of the injury event (E 849.X). Relevant ICD-9-CM code value for injury event	W

Trauma Data Code Tables

Table 1. DPH and CHIA Organization IDs for Hospitals

DPHOrg ID	CHIAOrgID	Organization Name
2006	1	Anna Jaques Hospital
2226	2	Athol Memorial Hospital
2120	5	Baystate Franklin Medical Center
2148	6	Baystate Mary Lane Hospital
2339	4	Baystate Medical Center
2181	139	Baystate Wing Memorial Hospital
2313	7	Berkshire Medical Center –725 North Street
2227	98	Beth Israel Deaconess Hospital - Milton
2054	53	Beth Israel Deaconess Hospital - Needham
2082	79	Beth Israel Deaconess Hospital - Plymouth
2069	10	Beth Israel Deaconess Medical Center - East Campus
2092	140	Beth Israel Deaconess Medical Center - West Campus
2016	109	Beverly Hospital - Addison Gilbert Campus
2007	110	Beverly Hospital - Lahey Health
2139	46	Boston Children's Hospital
2084	144	Boston Medical Center - East Newton Campus
2307	16	Boston Medical Center - Menino Pavilion
2048	59	Brigham and Women'sFaulkner Hospital
2341	22	Brigham and Women's Hospital
2108	27	Cambridge Health Alliance - Cambridge Campus
2001	143	Cambridge Health Alliance - Somerville Campus
2046	142	Cambridge Health Alliance - Whidden Memorial Campus
2135	39	Cape Cod Hospital
2003	42	Carney Hospital - Steward Health Care Network
2126	132	Clinton Hospital
2155	50	Cooley Dickinson Hospital
2335	51	Dana-Farber Cancer Institute
2018	57	Emerson Hospital
2052	8	Fairview Hospital
2289	40	Falmouth Hospital
2311	62	Good Samaritan Medical Center - Steward Health Care Network
2038	66	Hallmark Health System - Lawrence Memorial Hospital

2058	141	Hallmark Health System - Melrose-Wakefield Hospital
2143	68	Harrington Hospital
2036	73	Heywood Hospital
2225	75	Holy Family Hospital - Steward Health Care Network
2131	11466	Holy Family Hospital at Merrimack Valley - Steward Health Care Network (old number 70)
2145	77	Holyoke Medical Center
2091	136	Kindred Hospital Boston
2171	135	Kindred Hospital Boston North Shore
2342	81	Lahey Hospital & Medical Center - Burlington
2161	4448	Lahey Medical Center North Shore/Peabody
2099	83	Lawrence General Hospital
2040	85	Lowell General Hospital
2029	115	Lowell General Hospital - Saints Campus
2103	133	Marlborough Hospital
2042	88	Martha's Vineyard Hospital
2167	89	Massachusetts Eye and Ear Infirmary
2168	91	Massachusetts General Hospital
2149	119	Mercy Medical Center - Springfield Campus
2020	49	MetroWest Medical Center - Framingham Union Campus
2039	457	MetroWest Medical Center - Leonard Morse/Natick
2105	97	Milford Regional Medical Center
2022	99	Morton Hospital - Steward Health Care Network
2071	100	Mount Auburn Hospital
2044	101	Nantucket Cottage Hospital
2298	11467	Nashoba Valley Medical Center - Steward Health Care Network (old number 52)
2059	103	New England Baptist Hospital
2075	105	Newton-Wellesley Hospital
2076	106	Baystate Noble Hospital
2014	116	North Shore Medical Center - Salem Campus
2008	3	North Shore Medical Center - Union Campus
2114	41	Norwood Hospital - Steward Health Care Network
2011	114	Saint Anne's Hospital - Steward Health Care Network
2128	127	Saint Vincent Hospital
2118	25	Signature Healthcare Brockton Hospital

2107	122	South Shore Hospital
2337	123	Southcoast Hospitals Group - Charlton Memorial Campus
2010	124	Southcoast Hospitals Group - St. Luke's Campus
2106	145	Southcoast Hospitals Group - Tobey Hospital Campus
2085	126	St. Elizabeth's Medical Center - Steward Health Care Network
2100	129	Sturdy Memorial Hospital
2299	104	Tufts Medical Center and Floating Hospital for Children (Pediatric Trauma)
2299	10177	Tufts Medical Center (Adult Trauma)
2127	8548	Umass Memorial Health Alliance Hospital - Burbank Campus
2127	8509	Umass Memorial Health Alliance Hospital - Leominister Campus (old number 71)
2124	130	UMass Memorial Medical Center - Memorial Campus
2841	131	UMass Memorial Medical Center - University Campus
2094	138	Winchester Hospital

Table 2. Postal State Codes

Valid Entries	Definition
AL	Alabama
AK	Alaska
AZ	Arizona
AR	Arkansas
CA	California
CO	Colorado
CT	Connecticut
DE	Delaware
DC	District of Columbia
FL	Florida
GA	Georgia
HI	Hawaii
ID	Idaho
IL	Illinois
IN	Indiana
IA	Iowa

KS	Kansas
KY	Kentucky
LA	Louisiana
ME	Maine
MD	Maryland
MA	Massachusetts
MI	Michigan
MN	Minnesota
MS	Mississippi
MO	Missouri
MT	Montana
NE	Nebraska
NV	Nevada
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NY	New York
NC	North Carolina
ND	North Dakota
OH	Ohio
OK	Oklahoma
OR	Oregon
PA	Pennsylvania
RI	Rhode Island
SC	South Carolina
SD	South Dakota
TN	Tennessee
TX	Texas
UT	Utah
VT	Vermont
VA	Virginia
WA	Washington
WV	West Virginia
WI	Wisconsin
WY	Wyoming

Table 3. Level of Service

Valid Entries	Definition
1	Outpatient Emergency Department Stay
2	Outpatient Observation Stay
3	Inpatient Stay
4	Death on Arrival

Massachusetts Trauma .XSD

Please note that we are not strictly validating against the .XSD, it is for reference purposes only. Since we accept data in both XML and fixed length, the majority of data validation happens after the data is loaded from the XML file into the data base environment.

Note: When writing up the XML element tags, the coding should not include "biu=" . For example, HomeCity should be coded as <HomeCity>76678</HomeCity> rather than something like <HomeCity biu='76678'/>.

```
<?xmlversion="1.0"encoding="UTF-8"?>
<xs:schemaxmlns:xs="http://www.w3.org/2001/XMLSchema"elementFormDefault="qualified"attrib
uteFormDefault="unqualified">
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<xs:documentation>Root Tag</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:sequence>
<xs:elementname="MDPHTraumaRecord"minOccurs="1"maxOccurs="unbounded">
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<xs:all>
<xs:elementname="PatientId">
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<xs:documentation>Patient's Social Security Number.</xs:documentation>
</xs:annotation>
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</xs:simpleType>
</xs:element>
<xs:elementname="FacilityId">
<xs:annotation>
<xs:documentation>The CHIA Filing OrgID</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="FacilitySiteId">
<xs:annotation>
<xs:documentation>The CHIA Facility Site Org ID</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="InterFacilityTransfer">
<xs:annotation>
<xs:documentation>Determination if the patient was transferred from another acute care
facility.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="InterFacilityTransfer">
<xs:attributeref="biu" />
</xs:extension>
```

```
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="FacilitySiteIdOfTransferringHospital">
<xs:annotation>
<xs:documentation>Facility Site ID of Transferring Hospital</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="DPHFacilityIDNumber">
<xs:annotation>
<xs:documentation>A number assigned by the Department of Public Health to identify the
facility.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="DepartureTimeSceneOrTransferring">
<xs:annotation>
<xs:documentation>Time the patient left the originating hospital if a transfer
patient.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="Time">
<xs:attributeref="biu"/>
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="HospitalArrivalDate">
<xs:annotation>
<xs:documentation>The date and time the patient arrived to the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="HospitalArrivalDate">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="HospitalArrivalTime">
<xs:annotation>
<xs:documentation>The date and time the patient arrived to the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="HospitalArrivalTime">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
```

```
<xs:elementname="EDDischargeDate">
<xs:annotation>
<xs:documentation>The date and time the patient arrived to the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="EDDischargeDate">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="EDDischargeTime">
<xs:annotation>
<xs:documentation>The date and time the patient arrived to the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="EDDischargeTime">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="MedicalRecordNumber">
<xs:annotation>
<xs:documentation>Patient’s hospital Medical Record Number.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="DateOfBirth">
<xs:annotation>
<xs:documentation>The patient's date of birth.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="DateOfBirth">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
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<xs:annotation>
<xs:documentation>The patient's sex.</xs:documentation>
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<xs:simpleContent>
<xs:extensionbase="Sex">
<xs:attributeref="biu" />
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</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="PatientStreetAddress">
```

```
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<xs:documentation>Patient’s Street Address.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="HomeCity">
<xs:annotation>
<xs:documentation>The patient's home city (or township, village) of
residence.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="HomeCity">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="HomeZip">
<xs:annotation>
<xs:documentation>The patient's home ZIP code of residence</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="Zip">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="PatientHomeCountry">
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<xs:documentation>The country where the patient resides.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="PatientHomeCounty">
<xs:annotation>
<xs:documentation>The patient's county(or parish) of residence.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="AlternateHomeResidence">
<xs:annotation>
<xs:documentation>Documentation of the type of patient without a homeZIP/Postal
code.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="Age">
<xs:annotation>
```

```
<xs:documentation>The patient'sage atthe time of injury (best
approximation).</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="AgeUnits">
<xs:annotation>
<xs:documentation>The units used to document the patient's age (Minutes,Hours,
Days,Months, Years).</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="Ethnicity">
<xs:annotation>
<xs:documentation>The patient'sethnicity.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="PatientOccupationalIndustry">
<xs:annotation>
<xs:documentation>The occupational industryassociated with the patient's work
environment.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="PatientOccupation">
<xs:annotation>
<xs:documentation>The occupation of the patient.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="ICD10PrimaryExternalCauseCode">
<xs:annotation>
<xs:documentation>The primary external cause code should describe the main reason a
patient is admitted to the hospital.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="ICD10PlaceofOccurrenceExternalCauseCode">
<xs:annotation>
<xs:documentation>Place of occurrence external cause code used to describe the
place/site/locationof the injury event (Y92.x).</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
```

```
<xs:elementname="IncidentLocationPostalCode">
<xs:annotation>
<xs:documentation>The ZIP/Postal code of the incidentlocation.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="IncidentCountry">
<xs:annotation>
<xs:documentation>The country where the patient was found or to whichthe unit responded
(or bestapproximation).</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="IncidentCounty">
<xs:annotation>
<xs:documentation>The county or parish where the patient was found or towhich the
unitresponded (or bestapproximation).</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="ReportofPhysicalAbuse">
<xs:annotation>
<xs:documentation>A report of suspected physical abuse was made to law enforcement and/or
protective services.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InvestigationofPhysicalAbuse">
<xs:annotation>
<xs:documentation>An investigation by law enforcementand/or protective services
wasinitiated because of the suspected physical abuse.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="CaregiveratDischarge">
<xs:annotation>
<xs:documentation>The patient was discharged to a caregiver different than the caregiver
at admission due to suspected physical abuse.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="EMSDispatchDate">
<xs:annotation>
<xs:documentation>The date the unit transporting to your hospital was notified by
dispatch.</xs:documentation>
</xs:annotation>
</xs:element>
```

```
<xs:elementname="EMSDispatchTime">
<xs:annotation>
<xs:documentation>The time the unit transporting to your hospital was notified by
dispatch.</xs:documentation>
</xs:annotation>
</xs:element>
<xs:elementname="EMSUnitArrivalDateatSceneorTransferringFacility">
<xs:annotation>
<xs:documentation>The date the unit transporting to your hospital arrived on the
scene/transferring facility.</xs:documentation>
</xs:annotation>
</xs:element>
<xs:elementname="EMSUnitArrivalTimeatSceneorTransferringFacility">
<xs:annotation>
<xs:documentation>The time the unit transporting to your hospital arrived on the
scene.</xs:documentation>
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</xs:element>
<xs:elementname="EMSUnitDepartureDatefromSceneorTransferringFacility">
<xs:annotation>
<xs:documentation>The date the unit transporting to your hospital left the
scene.</xs:documentation>
</xs:annotation>
</xs:element>
<xs:elementname="EMSUnitDepartureTimefromSceneorTransferringFacility">
<xs:annotation>
<xs:documentation>The time the unit transporting to your hospital leftthe
scene.</xs:documentation>
</xs:annotation>
</xs:element>
<xs:elementname="InitialFieldsystolicbloodpressure">
<xs:annotation>
<xs:documentation>First recorded systolic blood pressure measured at the scene of
injury.</xs:documentation>
</xs:annotation>
<xs:simpleType>
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</xs:simpleType>
</xs:element>
<xs:elementname="InitialFieldPulseRate">
<xs:annotation>
<xs:documentation>First recorded pulse measured at thescene of injury (palpated or
auscultated), expressed as a number perminute.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialFieldRespiratoryRate">
<xs:annotation>
<xs:documentation>First recorded respiratory rate measured at the scene ofinjury
(expressed as a number per minute).</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialFieldOxygenSaturation">
<xs:annotation>
```

```
<xs:documentation>First recorded oxygen saturation measured atthe scene of injury
(expressed as a percentage).</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialFieldGCSEYE">
<xs:annotation>
<xs:documentation>First recorded Glasgow Coma Score (Eye) measuredat the scene of
injury.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialFieldGCSVerbal">
<xs:annotation>
<xs:documentation>First recorded Glasgow Coma Score (Verbal) measured at the scene of
injury.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialFieldGCSMotor">
<xs:annotation>
<xs:documentation>First recorded Glasgow Coma Score (Motor) measured at thescene of
injury.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialFieldGCSTotal">
<xs:annotation>
<xs:documentation>First recorded Glasgow Coma Score (total) measured at the scene of
injury.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="Traumacentercriteria">
<xs:annotation>
<xs:documentation>Physiologic and anatomic EMS trauma triage criteria for transport to a
trauma center.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="Vehicularpedestrianotherriskinjury">
<xs:annotation>
<xs:documentation>EMS trauma triage mechanism of injury criteria for transport to a
trauma center.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
```

```
</xs:simpleType>
</xs:element>

<xs:elementname="Prehospitalcardiacarrest">
<xs:annotation>
<xs:documentation>Indication of whether patient experienced cardiac arrest prior to
ED/Hospital arrival.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>

<xs:elementname="InitialEDHospitaltemperature">
<xs:annotation>
<xs:documentation>First recorded temperature (in degrees Celsius [centigrade]) in the
ED/hospitalwithin 30 minutes or less of ED/hospital arrival.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:string" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialEDHospitalRespiratoryAssistance">
<xs:annotation>
<xs:documentation>Determination ofrespiratory assistance associated with the initial
ED/hospital respiratoryrate within 30 minutes or lessof ED/hospital
arrival.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialEDHospitalOxygenSaturation">
<xs:annotation>
<xs:documentation>First recorded oxygen saturation in theED/hospital within 30 minutes or
less of ED/hospital arrival (expressed as a percentage).</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialEDHospitalSupplementalOxygen">
<xs:annotation>
<xs:documentation>Determination of the presence of supplemental oxygen during assessment
ofinitial ED/hospital oxygen saturation level within 30minutes or less of ED/hospital
arrival.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="InitialEDHospitalHeight">
<xs:annotation>
<xs:documentation>First recorded height upon ED/hospitalarrival.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
```

```
<xs:elementname="InitialEDHospitalweight">
<xs:annotation>
<xs:documentation>Measured or estimated baseline weight.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="EDDischargeDisposition">
<xs:annotation>
<xs:documentation>The disposition of the patient at the time of discharge from the
ED.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="Signsoflife">
<xs:annotation>
<xs:documentation>Indication of whether patient arrived atED/Hospitalwith signs of
life.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="TotalICULengthofStay">
<xs:annotation>
<xs:documentation>The cumulative amount of time spent in the ICU. Each partial or full
day should be measured as one calendar day.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="TotalVentilatorDays">
<xs:annotation>
<xs:documentation>The cumulative amount of time spent onthe ventilator. Each partialor
full day should be measured as one calendar day.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="HospitalDischargeDate">
<xs:annotation>
<xs:documentation>The date theorder waswritten for the patient to be discharged fromthe
hospital.</xs:documentation>
</xs:annotation>
</xs:element>
<xs:elementname="HospitalDischargeTime">
<xs:annotation>
<xs:documentation>The time the order was written for the patient to be discharged from
the hospital.</xs:documentation>
</xs:annotation>
</xs:element>
<xs:elementname="ICD10HospitalProcedureCode">
<xs:complexType>
<xs:sequence>
```

```
<xs:elementname="item"maxOccurs="200">
<xs:complexType>
<xs:sequence>
<xs:elementname="ICD10HospitalProcedureCode">
<xs:annotation>
<xs:documentation>Major and minor procedure ICD-10-CM procedurecodes.</xs:documentation>
</xs:annotation>
</xs:element>
<xs:elementname="HospitalProcedureStartDate">
<xs:annotation>
<xs:documentation>The date operative and selectednon-operative procedures were
performed.</xs:documentation>
</xs:annotation>
</xs:element>
<xs:elementname="HospitalProcedureStartTime">
<xs:annotation>
<xs:documentation>The time operative and selected non-operative procedures were
performed.</xs:documentation>
</xs:annotation>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
<xs:elementname="HospitalDischargeDisposition">
<xs:annotation>
<xs:documentation>The disposition of the patient when discharged from the
hospital.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="PrimaryMethodofPayment">
<xs:annotation>
<xs:documentation>Primary source of paymentfor hospital care.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="Race1">
<xs:annotation>
<xs:documentation>The patient's race.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
<xs:elementname="Race2">
<xs:annotation>
<xs:documentation>The patient's race.</xs:documentation>
</xs:annotation>
<xs:simpleType>
<xs:restrictionbase="xs:integer" />
</xs:simpleType>
</xs:element>
```

```
<xs:elementname="AdditionalICD10ExternalCauseCode">
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<xs:sequence>
<xs:elementname="item"maxOccurs="50">
<xs:complexType>
<xs:sequence>
<xs:elementname="AdditionalICD10ExternalCauseCode">
<xs:annotation>
<xs:documentation>Additional External Cause Code used in conjunction with the Primary
External Cause Code if multiple external cause codes are required to describe the injury
event.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="AdditionalICD10ExternalCauseCode">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="IncidentDate">
<xs:annotation>
<xs:documentation>The date the injury occurred.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="IncidentDate">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="IncidentTime">
<xs:annotation>
<xs:documentation>The time the injury occurred.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="Time">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="WorkRelated">
<xs:annotation>
<xs:documentation>Indication of whether the injury occurred during paid
employment.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="WorkRelated">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="TransportMode">
<xs:annotation>
```

```
<xs:documentation>The mode of transport delivering the patient to your
hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="WorkRelated">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="ServiceLevel">
<xs:annotation>
<xs:documentation>The highest level of service provided in the hospital
setting.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="ServiceLevel">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="IncidentCity">
<xs:annotation>
<xs:documentation>The city or township where the patient was found or to which the unit
responded (or best approximation).</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="IncidentCity">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="IncidentState">
<xs:annotation>
<xs:documentation>The State where the patient was found or to which the unit responded
(or best approximation).</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="IncidentState">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="AlcoholUseIndicators">
<xs:annotation>
<xs:documentation>Use of alcohol by the patient.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="AlcoholUseIndicators">
<xs:attributeref="biu" />
</xs:extension>
```

```
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="DrugUseIndicators">
<xs:complexType>
<xs:sequence>
<xs:elementname="item"maxOccurs="2">
<xs:complexType>
<xs:sequence>
<xs:elementname="DrugUseIndicator">
<xs:annotation>
<xs:documentation>Use of drugs by the patient.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="DrugUseIndicator">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
<xs:elementname="GcsEye">
<xs:annotation>
<xs:documentation>First recorded Glasgow Coma Score (Eye) in the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="GcsEye">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="GcsVerbal">
<xs:annotation>
<xs:documentation>First recorded Glasgow Coma Score (Verbal) in the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="GcsVerbal">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="GcsMotor">
<xs:annotation>
<xs:documentation>First recorded Glasgow Coma Score (Motor) in the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
```

```
<xs:simpleContent>
<xs:extensionbase="GcsMotor">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="TotalGcs">
<xs:annotation>
<xs:documentation>First recorded Glasgow Coma Score (total) in the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="TotalGcs">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="GcsQualifiers">
<xs:complexType>
<xs:sequence>
<xs:elementname="item"maxOccurs="3">
<xs:complexType>
<xs:sequence>
<xs:elementname="GcsQualifier">
<xs:annotation>
<xs:documentation>Documentation of factors potentially affecting the first assessment of
GCS upon arrival in the ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="GcsQualifier">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
<xs:elementname="RespiratoryRate">
<xs:annotation>
<xs:documentation>First recorded respiratory rate in the ED/hospital (expressed as a
number per minute).</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="RespiratoryRate">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="Sbp">
```

```
<xs:annotation>
<xs:documentation>First recorded systolic blood pressure in the
ED/Hospital</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="Sbp">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="PulseRate">
<xs:annotation>
<xs:documentation>First recorded systolic blood pressure in the
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="PulseRate">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="PrimaryEcodeICD9CM">
<xs:annotation>
<xs:documentation>ECode used to describe the mechanism (or external factor) that caused the injury event.(If two or more events cause separate injuries, an E code should be assigned for each cause. The first-listed E code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm. A code for the ICD-9-CM external cause of injury that permits classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.)
</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="PrimaryEcodeICD9CM">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="LocationEcodeICD9CM">
<xs:annotation>
<xs:documentation>E-code used to describe the place/site/location of the injury event (E 849.X). Relevant ICD-9-CM code value for injury event.
</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="LocationEcodeICD9CM">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="InjuryDiagnoses">
<xs:complexType>
```

```
<xs:sequence>
<xs:elementname="item"maxOccurs="50">
<xs:complexType>
<xs:sequence>
<xs:elementname="InjuryDiagnosis">
<xs:annotation>
<xs:documentation>Diagnoses related to all identified injuries.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="InjuryDiagnosis">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="AIS">
<xs:annotation>
<xs:documentation>AIS numerical injury identifier.Must be a valid AIS 90 code. Must
consist of 6 numbers followed by a decimal point followed by 1 number. The number
following the decimal point must be as specified in Data Code Tables.  (Table 10) (1-
6).</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="AIS">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="AISVersion">
<xs:annotation>
<xs:documentation>Indicates which version of AIS is used to calculate AIS90.  Only the
1998 revision of AIS90 or an earlier version are accepted.Must be present for each
Diagnosis Code. Must be 85, 90 or 98.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="AISVersion">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="ICD9CMDiagnosisCode">
<xs:annotation>
<xs:documentation>Must be present.
Must be valid ICD-9-CM code. (exclude decimal point).</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="ICD9CMDiagnosisCode ">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
```

```
</xs:sequence>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
<xs:elementname="ProtectiveDevices">
<xs:complexType>
<xs:sequence>
<xs:elementname="item"maxOccurs="unbounded">
<xs:complexType>
<xs:sequence>
<xs:elementname="ProtectiveDevice">
<xs:annotation>
<xs:documentation>Protective devices (safety equipment) in use or worn by the patient at
the time of the injury.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="ProtectiveDevice">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
<xs:elementname="ChildSpecificRestraint">
<xs:annotation>
<xs:documentation>Protective child restraint devices used by patient at the time of
injury.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="ChildSpecificRestraint">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
<xs:elementname="AirbagDeployments">
<xs:complexType>
<xs:sequence>
<xs:elementname="item"maxOccurs="unbounded">
<xs:complexType>
<xs:sequence>
<xs:elementname="AirbagDeployment">
<xs:annotation>
<xs:documentation>Indication of an airbag deployment during a motor vehicle
crash.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="AirbagDeployment">
<xs:attributeref="biu" />
```

```
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
<xs:elementname="OtherTransportMode">
<xs:complexType>
<xs:sequence>
<xs:elementname="item"maxOccurs="5">
<xs:annotation>
<xs:documentation>All other modes of transportused during patient care event (prior to
arrival at your hospital),except the mode delivering the patientto the
hospital.</xs:documentation>
</xs:annotation>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
<xs:elementname="ComorbidConditions">
<xs:complexType>
<xs:sequence>
<xs:elementname="item"maxOccurs="5">
<xs:complexType>
<xs:sequence>
<xs:elementname="ComorbidCondition">
<xs:annotation>
<xs:documentation>Pre-existing comorbid factors present at patient arrive to
ED/hospital.</xs:documentation>
</xs:annotation>
<xs:complexType>
<xs:simpleContent>
<xs:extensionbase="ComorbidCondition">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
<xs:elementname="HospitalComplications">
<xs:complexType>
<xs:all>
<xs:elementname="item"maxOccurs="10">
<xs:complexType>
<xs:sequence>
<xs:elementname="HospitalComplication">
<xs:annotation>
<xs:documentation>Diagnoses related to all identified injuries.</xs:documentation>
</xs:annotation>
<xs:complexType>
```

```
<xs:simpleContent>
<xs:extensionbase="HospitalComplication">
<xs:attributeref="biu" />
</xs:extension>
</xs:simpleContent>
</xs:complexType>
</xs:element>
</xs:sequence>
</xs:complexType>
</xs:element>
</xs:all>
</xs:complexType>
</xs:element>
</xs:all>
</xs:complexType>
</xs:element>
</xs:sequence>
<xs:attributename="MDPHTraumaVersion"use="required"fixed="v1.0.0" />
</xs:complexType>
</xs:element>
</xs:schema>
```

Massachusetts Trauma Sample XML File

Please note that the purpose of this sample is to show sample XML formatting. It is not meant to show realistic data.

Note: When writing up the XML element tags, the coding should not include "biu=" . For example, HomeCity should be coded as <HomeCity>76678</HomeCity> rather than something like <HomeCity biu='76678'/>.

```
<?xml version="1.0"?>
<MDPHTraumaRecords MDPHTraumaVersion="v1.0.0">
<MDPHTraumaRecord>
        <PatientId>099889995</PatientId>
        <FacilityId>105</FacilityId>
        <FacilitySiteId>105</FacilitySiteId>
<InterFacilityTransfer>1</InterFacilityTransfer>
<FacilitySiteIdOfTransferringHospital>16</FacilitySiteIdOfTransferringHospital>
<EDDischargeDate>2016-01-01</EDDischargeDate>
<EDDischargeTime>05:05</ EDDischargeTime >
<HospitalArrivalDate>2016-01-01</HospitalArrivalDate>
<HospitalArrivalTime>05:05</HospitalArrivalTime>
        <MedicalRecordNumber>567765345</MedicalRecordNumber>
<DateOfBirth>1978-04-24</DateOfBirth>
        <Sex>1</Sex>
        <PatientStreetAddress>100 Main Street</PatientStreetAddress>
<HomeCity>76678</HomeCity>
<HomeZip>02702</HomeZip>
<IncidentDate>2016-01-01</IncidentDate>
<IncidentTime>13:02</IncidentTime>
<WorkRelated>1</WorkRelated>
<TransportMode>4</TransportMode>
<IncidentCity>12345</IncidentCity>
<AlcoholUseIndicators>2</AlcoholUseIndicators>
<DrugUseIndicators>
<item>
<DrugUseIndicator>3</DrugUseIndicator>
</item>
<item>
<DrugUseIndicator>2</DrugUseIndicator>
</item>
</DrugUseIndicators>
<GcsEye>1</GcsEye>
<GcsVerbal>2</GcsVerbal>
<GcsMotor>4</GcsMotor>
<TotalGcs>7</TotalGcs>
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